LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

Balancing Rights?

Dangerous Offenders with Severe Personality Disorders, the Public, and the Promise of Rehabilitation

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Declaration

I certify that the thesis I have presented for examination for the MPhil/PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

I warrant that this authorisation does not, to the best of my belief, infringe the rights of any third party.

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I can confirm that parts of Chapter 1 and Chapter 7 were the result of previous study for the MSc in Criminology and Criminal Justice at the University of Oxford.

Abstract

This thesis examines the emergence of the concept of dangerous and severe personality disorder (DSPD) in England and Wales and its subsequent interactions with criminal justice and health policy, mental health law and the law of sentencing. It also presents a normative critique of the promise of rehabilitation as a limit on the preventive detention of offenders perceived to be dangerous and personality disordered. In the first part of the thesis it is argued that the DSPD initiative was a compromise between the objectives of the Home Office and Department of Health intended to provide a solution to the long-standing problems personality disordered offenders presented for the prison and secure hospital systems. The plans also sought to strike a "balance" between the recognised rights of the offender to liberty and the more contested and nebulous "right" of the public to protection against harm. In essence, the bargain struck meant that, in exchange for their detention to protect the public, dangerous offenders with severe personality disorders would be offered tailored treatments aimed at alleviating their personal distress and reducing the risks they posed to the public so that they could eventually be released. Problematically, however, the effectiveness of the treatments on offer in reducing risk has not yet been proven. In the second part of the thesis, it emerges that the domestic and European legal framework governing the DSPD group takes a similar approach to "balancing" competing rights. In the final analysis, however, the legal and policy framework prioritises the pursuit of public security over the rights of the offender and risk subjecting the latter to disproportionate punishment. In this context, it is argued that the promise of rehabilitation may be more accurately characterised as means of rendering the coercive practice of preventive detention more palatable for liberal governments than as a true safeguard against the violation of prisoners' rights. Finally, some suggestions for a new normative framework that is more responsive to the risks of disproportionate punishment presented by the current system are put forward.

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Chapter 1: Introduction

1. Introducing the DSPD Programme and the OPDP

In 1999, Tony Blair's Labour government published radical proposals aimed at protecting the public from dangerous individuals suffering from severe forms of personality disorder (Home Office and Department of Health 1999). Individuals in the newly-created "Dangerous and Severe Personality Disordered" (DSPD) category were presented by politicians and policymakers as having fallen through the cracks in the mental health and criminal justice systems due to gaps in the law and the refusal of some psychiatrists to take responsibility for patients they considered to be "untreatable". The plans were widely interpreted by the media as a response to the case of Michael Stone, convicted of the horrific murders of Lin Russell and her younger daughter Megan and the attempted murder of Lin's elder daughter, Josie, in Chillenden, Kent in July 1996 (Francis *et al.* 2006, p.11). Following his arrest, media reports described Stone as a "psychopath" left free to kill after psychiatrists had refused to admit him to hospital on the grounds that he was "untreatable" or "too dangerous" (Francis *et al.* 2006, Table 1.14).

The government's plans were outlined in a joint Home Office and Department of Health consultation paper entitled *Managing Dangerous People with Severe Personality Disorder* published in 1999. The paper asserted that a significant number of individuals in the DSPD group had been given determinate sentences by the courts and had to be released from prison at the end of their sentences despite the risks they posed to the public due to "serious anti-social behaviour resulting from their disorder" (Home Office and Department of Health 1999, p.12). At the time, the Mental Health Act (MHA) 1983 only permitted the detention of individuals suffering from "psychopathic disorder" in psychiatric institutions if it could be shown that treatment was "likely to alleviate or prevent a deterioration" in their condition (former s.3.(2)(b)). As personality disorders were considered "untreatable" by some psychiatrists, the "treatability" criterion was presented as a stumbling block to the detention of dangerous individuals to protect the public (Seddon 2008 p.304; Peay 2011b, p.176).

The paper put forward proposals to establish new powers for the detention of individuals in the DSPD group in a dedicated institution, separate from prisons and secure hospitals, for as long as they posed a risk. Detention would not depend on a criminal conviction but would instead fall within the state's power to detain individuals "of unsound mind" under Article 5.1(e) of the European Convention on Human Rights (ECHR). The DSPD group would not merely be detained, however, but would also be "helped and encouraged to co-operate in therapeutic and other activity designed to help them return safely to the community" (Home Office and Department of Health 1999, p.9). By allocating significant funding to research into tailored treatments, the government aimed to strike a "balance" "between the human rights of individuals [in the DSPD group] and the right of the public to be protected from these very dangerous people" (Boateng and Sharland 1999, p.7). If the risks posed by those in the DSPD group were found not to be reduced through treatment, however, there would be "no alternative but to continue to detain them indefinitely" (Home Office and Department of Health 1999, p.9).

The proposals faced strident opposition from psychiatrists, lawyers, patient groups and civil liberties charities. In particular, psychiatrists were concerned about the ethical implications of detaining a group in hospital that was unlikely to benefit from treatment. Some feared that they would be expected to perform the role of "judges and jailers" and perform the function of maintaining social order (Mullen 1999, p.1146). Legal commentators expressed the suspicion that the government aimed to circumvent the provisions of the ECHR and detain suspected offenders without the need for a criminal trial and conviction (Eastman 1999a). The plans were eventually shelved. Instead, a number of pilot units were established in prisons, secure hospitals and in the community to develop and test assessment and treatment processes for the DSPD group within existing legal frameworks (Department of Health 2000b).

Meanwhile, the government pushed forward reforms to mental health legislation, which eventually resulted in the implementation of the MHA 2007. Amongst other changes, the MHA 2007 replaced the "treatability" criterion with a requirement that "appropriate medical treatment" be "available" to the patient and that the "purpose" of this treatment be "to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations" (MHA1983, s.145(4)). Thus the test became "not predictive but aspirational" (Peay 2011a, p.238). A parallel development was the introduction of the

sentence of imprisonment for public protection (IPP) by the Criminal Justice Act (CJA) 2003. Like the DSPD proposals, the IPP targeted the problem of dangerous offenders released from determinate prison sentences (Annison 2015). Unlike the reforms to the MHA 1983, the IPP was prospective and applied after conviction to individuals who had a previous conviction for a listed offence and who were judged to pose a "significant risk" of "serious harm" to the public (CJA 2003, s.225(1)(b)). Like a life sentence, the IPP was composed of a punitive tariff and a period of preventive detention that would continue until the Parole Board was "satisfied that it [was] no longer necessary for the protection of the public that the prisoner should be confined" (Crime Sentences Act 1997, s.28(6)(b)). Control was also extended over the DSPD group in the community through post-release supervision requirements and a raft of civil preventive orders with criminal penalties for breach, such as Violent Offender Orders (VOOs) and Sexual Offences Prevention Orders (SOPOs). Taken together, these incremental developments have largely accomplished what the 1999 proposals set out to achieve but with comparatively little scrutiny or controversy.

Early evaluations of the ability of the DSPD programme to assess and treat the offenders in its care were predominantly negative (Barrett *et al.* 2009; Tyrer *et al.* 2007; 2009; 2010). Professor Peter Tyrer and others in the IMPALOX (Imperial College, Arnold Lodge and Oxford University) group expressed concerns that only 10% of the time spent by prisoners on the DSPD programme could be classified as therapy (Tyrer *et al.* 2010). In view of their findings, the authors expressed the suspicion that the programme was engaged in the mere "warehousing" of offenders the government was too afraid to release and that public protection would triumph over treatment in the event of conflict (Tyrer *et al.* 2010, p.97). In sum, they concluded that their "findings, together with concerns about treatability, raise[d] more fundamental concerns about whether medical management of people with these problems is a justifiable use of resources and ethically appropriate" (Tyrer *et al.* 2009, p.144).

Later evaluations appeared to give some weight to the accusation of "warehousing" (Tyrer *et al.* 2010, p.97). The *Inclusion for DSPD: Evaluating Assessment and Treatment* (IDEA) study conducted by researchers at the University of Oxford reported the surprising finding that formal therapy took up an average of less than two hours per week in the DSPD units (Burns *et al.* 2011, p.237). The *Multi-method Evaluation of the*

Management, Organisation and Staffing in High Security Treatment Services for People with Dangerous and Severe Personality Disorder (MEMOS) conducted by researchers at Imperial College found that movement through the hospital and prison DSPD units was slow and that the hospital units were being used to detain prisoners who had passed the date at which they could be expected to be released from a determinate prison sentence (Trebilcock and Weaver 2010a; 2010b). More positive findings included a reduction in actuarial risk of violence scores across the sample and fewer violent incidents than would have been expected given the profile of those detained (Department of Health 2011). Due to the lack of a control group, however, it was not clear if these changes could be attributed to treatment or to other factors affecting the participants (Burns *et al.* 2011).

The findings of the IDEA and MEMOS studies in relation to treatment are surprising given the emphasis on therapy in policy documents and programme delivery guides (see Home Office and Department of Health 1999; DSPD Programme *et al.* 2008a; 2006). As I have argued in earlier work, they also raise the possibility that the DSPD programme may have been a means of justifying the extended detention of offenders in secure hospitals purely for public protection (O'Loughlin 2014). On the other hand, those involved in the development and implementation of the DSPD programme have strongly refuted accusations that the programme was engaged in mere "warehousing" (Howells *et al.* 2011, p.131-2). The vast sums of money expended on developing interventions and purpose-built therapeutic environments also indicate that the programme is unlikely to have been a mere cover for preventive detention. Nevertheless, the results of the evaluations indicate that the DSPD programme failed in some respects to live up to the expectations set for it by policymakers.

Despite the results of the evaluations, the Conservative-Liberal Democrat Coalition government that succeeded Labour in 2010 promised to continue and even expand the DSPD programme in prisons while dismantling the hospital units under the new, less stigmatising title of the Offender Personality Disorder Pathway (OPDP) (Department of Health and NOMS 2011a; 2011b). The plans for the OPDP form part of a broader strategy of reviving rehabilitation as an aim of the criminal justice system pursued by the Coalition and continued by the Conservative government that took over in 2015 (Ministry of Justice 2010a; 2013a; 2015d). The choice to expand the programme in prisons appears questionable, however, in light of the evaluations and of the continuing

ethical and legal difficulties associated with the detention and treatment of personality disordered offenders.

2. Research Aims

This thesis will examine the DSPD programme and the OPDP as a recent set of responses to the longstanding and complex dilemmas presented by personality disordered individuals who are considered dangerous. The initiatives offer an important opportunity for testing the explanatory power of the claims of the current criminological literature on broader trends in criminal justice policy. Most notably, they cut across the interface between the mental health and criminal justice systems and appear as examples of the recent revival of rehabilitation with a "late-modern" flavour (Robinson 2008). Through the OPDP, the legacy of the DSPD initiative continues to have an impact on the rights and interests of offenders in the current system and one that is constantly evolving. The OPDP is therefore an important object of study in itself as it interacts with the intricate web of sentencing provisions, mental health legislation and administrative powers that has come to govern the DSPD group since its creation in 1999.

The work presented in this thesis is primarily exploratory in nature as it attempts to build a picture of how high risk personality disordered offenders are governed across two large and complex systems. It also seeks to unearth the assumptions underlying the current framework governing personality disordered offenders judged to be dangerous in order to expose them to critique. Finally, it puts forward some modest suggestions for a normative framework that is better equipped to avert the risks of excessive punishment posed by the current system and to take greater account of the particularities of personality disordered offenders.

3. Research Questions

The thesis addresses a number of key research questions. First, it investigates where the DSPD initiative came from, why it came about when it did, and what factors shaped it. Second, it asks whether criminological and penal theory can explain the seemingly

"hybrid" "tough" and "progressive" approach of the DSPD initiative and the tensions within it (Seddon 2008). Third, it explores why the initiative seems to have failed to live up to the expectations set for it and what lessons may be drawn from this for health and criminal justice policymaking. Fourth, it examines whether the reforms introduced by the OPDP and the combination of current law and policy is an appropriate response to the practical and normative problems posed by personality disordered offenders who are judged to be "dangerous". In particular, the thesis will critically examine whether the current legal framework may be said to strike an appropriate "balance" between the "right" of the public to protection from dangerous individuals claimed by the government (Boateng and Sharland 1999) and the competing rights of personality disordered offenders not to be subjected to arbitrary detention or disproportionate punishment.

4. Structure of the Thesis

The first half of the thesis explores the origins of the DSPD concept and its underlying assumptions. In so doing, it develops a critique of the DSPD programme and the OPDP in light of historical attempts to deal with personality disordered offenders and the evidence for the effective management and treatment of their disorders. This will set the scene for the second half of the thesis, which critically examines the manner in which personality disordered offenders are currently dealt with by the law and the criminal justice and mental health systems. The final substantive chapter, Chapter 7, draws together both halves in examining the assumptions that underlie law, policy and practice and the implications of the current framework for the rights and interests of personality disordered individuals who have offended. Finally, some suggestions will be put forward as to how the risks posed to the rights and interests of personality disordered offenders by the current system could be better managed and indicate the lines future research in this field could take.

This chapter will outline the methodological approach taken to answering the key research questions and introduce the main arguments of the thesis. It will also indicate how the research will refine and add to the body of existing empirical, normative and critical studies of the state's approach to managing those considered to be dangerous

and disordered. Before proceeding further, however, it is necessary to discuss the scientific, ethical and legal controversies surrounding the detention and treatment of personality disordered offenders considered to be dangerous and the challenges they present for law, policy and practice in further detail. This will provide the context for the evaluation of the current framework presented in the substantive chapters of the thesis.

5. Personality Disorder: Scientific, Ethical and Legal Controversies

(a) Contested diagnoses

The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV-TR, defines personality disorder as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in childhood or early adolescence, is stable over time, and leads to distress or impairment" (American Psychiatric Association 2000, p.685). The more recent DSM-V contains a definition similar to that found in DSM-IV-TR and an alternative experimental set of "general criteria for personality disorder" (American Psychiatric Association 2013, p.646-7; p.761). In the latter, the "essential features" of personality disorder are defined as "moderate or greater impairment in personality (self/interpersonal) functioning" and the presence of "one or more pathological personality traits" (American Psychiatric Association 2013, p.761). These features are "relatively inflexible and pervasive across a broad range of personal and social situations" and "relatively stable across time" (American Psychiatric Association 2013, p.761). The inclusion of "relatively" reflects developments in research showing variation and remission in the symptomatology of personality disorders over the life-course (Zanarini *et al.* 2003; Gutiérrez *et al.* 2012). This indicates that the disorders may not be as "enduring" and "inflexible" as previously thought.

DSM-V identifies three clusters of personality disorder: Cluster A: the "odd or eccentric" types; Cluster B: the "dramatic, emotional or erratic" types; and Cluster C: the "anxious and fearful" types (American Psychiatric Association 2013, p.646). Cluster B, which includes histrionic, narcissistic, antisocial and borderline personality disorders,

is of most relevance to criminality (Jones 2008, p.63). Antisocial personality disorder (ASPD) is described in the DSM-V as "a pattern of disregard for, and violation of, the rights of others". Borderline personality disorder (BPD) is characterised by "a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity" (American Psychiatric Association 2013, p.645). The traits and behaviours associated with ASPD include a failure to conform to social norms, deceitfulness, impulsivity, irritability and aggression, reckless disregard for the safety of self or others, irresponsibility and a lack of remorse (American Psychiatric Association 2013, p.659). The distinguishing features of BPD, on the other hand, include frantic efforts to avoid real or imagined abandonment, a pattern of unstable and intense interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal or self-mutilating acts, gestures, or threats, affective instability, chronic feelings of emptiness, inappropriate, intense anger or difficulties in controlling anger demonstrated by recurrent physical fighting, and transient, paranoid ideation or severe dissociative symptoms in times of stress (American Psychiatric Association 2013, p.663).

ASPD and narcissistic personality disorder (NPD) to some extent overlap with the construct of psychopathy. NPD is characterised by a pattern of "grandiosity, need for admiration, and lack of empathy" (American Psychiatric Association 2013, p.645). Psychopathy is defined by Robert D. Hare's *Psychopathy Checklist Revised* (PCL-R) (Hare 1991), a diagnostic tool divided into two factors: Factor 1 (interpersonal/affective) and Factor 2 (unstable and antisocial lifestyle). Factor 1 is further divided into an interpersonal facet, comprising the traits of glibness/superficial charm, grandiose sense of self-worth, pathological lying, conning and manipulativeness; and an affective facet, including lack of remorse or guilt, shallow affect, callousness/lack of empathy, and failure to accept responsibility for one's own actions. Factor 2 divides into a lifestyle facet, which includes a need for stimulation/proneness to boredom, parasitic lifestyle, lack of realistic long-term goals, impulsivity, irresponsibility; and an antisocial facet, comprising poor behavioural controls, early behavioural problems, juvenile delinquency, revocation of conditional release and criminal versatility (Hare 1991).

The prevalence of personality disorders amongst prisoners is up to ten times higher than that found in the general population (Fazel and Danesh 2002). A systematic review of

28 surveys on prisoner mental health from 12 countries found that 65% of male and 42% of female prisoners surveyed had been diagnosed with a personality disorder (Fazel and Danesh 2002). Of these, 47% of adult male prisoners had been diagnosed with ASPD and 21% and 25% of adult female prisoners had been diagnosed with ASPD and BPD respectively (Fazel and Danesh 2002). A survey of prisoners in England and Wales conducted by the Office of National Statistics found that 78% of male remand, 64% of male sentenced and 50% of female prisoners fulfilled the criteria for at least one personality disorder (Singleton *et al.* 1998, p. 10). Among a subset of prisoners who were clinically interviewed, 63% of male remand, 49% of male sentenced and 31% of female prisoners were assessed as having ASPD. Paranoid personality disorder (PPD), characterised by "a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent" (American Psychiatric Association 2013, p.645), was the second most prevalent personality disorder and affected 29% of male remand prisoners, 20% of male sentenced prisoners and 16% of sentenced female prisoners. At 20%, BPD was more prevalent than PPD amongst female prisoners (Singleton *et al.* 1998, p. 10).

These figures may come as no surprise as both ASPD and BPD incorporate offending behaviours into their diagnostic criteria. ASPD and psychopathy have been criticised for their circularity, as "the psychopath's mental disorder is inferred from his anti-social behaviour while the anti-social behaviour is explained by mental disorder" (Wootton 1981, p.90). According to one commentator, a diagnosis of ASPD or psychopathy "often does little more than recycle the history of prior offending behaviours in a different form, producing a potentially spurious association between personality disorder and offending" (Mullen 1999, p.1147). This begs the question of whether these disorders cause, explain or merely describe the socially undesirable acts and tendencies of those who are so diagnosed. The ASPD construct has also been criticised for its "moral overtones" (Gunn 2003) and one commentator has branded it as "a moral judgement masquerading as a clinical diagnosis" (Blackburn 1988, p.511). The finding of an "abnormal" personality that is stable and not amenable to change has also been characterised as "a clear moralistic position involving a long-term lack of confidence in those individuals who recurrently act in ways that others find offensive, disappointing and troublesome" (Pilgrim 2007, p.84). It has also been suggested that the diagnosis is tantamount to a declaration of dislike (Bowers *et al.* 2005, p.172; Lewis and Appleby 1988).

(b) Treating personality disorder

The law tends to find individuals diagnosed with personality disorders to be criminally responsible for their actions and they rarely benefit from defences available to mentally disordered offenders. Yet, as Jill Peay argues, some of the traits associated with their disorders indicate that "their ability to exercise control as others might over their behavio[u]r is impaired, albeit not extinguished" (Peay 2011a, p.232). Furthermore, owing to their emotional deficits, such individuals "may experience problems with feeling guilt, empathizing with their victims [and] learning from their experiences" and may therefore not respond to punishment and rehabilitative interventions in the expected ways (Peay 2011a, p.233).

The Court of Appeal in the recent case of *R. v. Vowles* [2015] EWCA Crim 45; [2015] 2 Cr. App. R. (S.) 6 advised that psychopathic or personality disordered offenders should be given prison sentences rather than hospital disposals. However, such individuals can prove very difficult to manage in prison as they are prone to manipulative, violent and self-harming behaviours and pose risks to themselves, staff and other prisoners. Neither do they fit easily into the mental health system. Psychiatrists see treating personality disordered patients as lengthy, intensive, expensive, of marginal benefit to patients, damaging to staff and services and disruptive of the treatment of others (Cawthra and Gibb 1998, p.8). Mental health care professionals have described them as "extremely difficult", "frustrating", "irritating, attention-seeking, difficult to manage and unlikely to comply with advice or treatment" (Kendell 2002), indicating that the presence of such patients has a negative impact on staff morale. Furthermore, treatment in hospital is of questionable benefit to those with ASPD as there is little robust evidence for effective psychological treatments (Warren *et al.* 2003; Gibbon *et al.* 2010). While there are more studies showing some support for interventions with BPD, the evidence continues to be limited by small sample sizes, short follow-up periods, the wide range of outcome measures used and poor controlling for comorbid psychopathologies (Bateman *et al.* 2015).

On the other hand, there is a growing literature on treatments that have shown some potential in treating personality disorders and a number of treatment models have emerged from the DSPD programme itself (e.g. Saradjian Murphy and McVey 2010; Tew and Atkinson 2013; Tennant and Howells 2010). Recent guidelines from the

National Institute for Health and Care Excellence (NICE) recommend challenging therapeutic pessimism and negative attitudes towards ASPD patients and encouraging staff to develop "a stronger belief in the effectiveness of their own personal skills" (NCCMH *et al.* 2010, para. 4.3.1). NICE also recommends exploring treatment options with BPD patients "in an atmosphere of hope and optimism, explaining that recovery is possible and attainable" (NCCMH *et al.* 2009, para. 4.6.2.1). The effectiveness of treatment may, however, be impeded by the fact that both offenders and those with personality disorders tend to have low motivation for treatment (Howells and Day 2007). In particular, those with ASPD tend to actively resist accepting help for their disorders (NCCMH *et al.* 2010, para. 2.4).

(c) Personality disorder and dangerousness

Mental disorder tends to be associated with dangerousness, violence and unpredictability in the mind of the public and in the media (see generally Thornicroft 2006; Peay 2011b). This can give rise to anxieties about the release of mentally disordered offenders from prisons and secure hospitals. When individuals previously in contact with the health and criminal justice systems go on to reoffend, the response of the public and media is often to blame those responsible for their care and to call for the government to "do something" about the problem. However, the limits of current scientific knowledge in estimating and predicting risk means that formulating rational policies in response to these calls is a difficult business.

There is evidence showing that the risk of violent offending amongst those with personality disorder is about three times that of the general population (Yu *et al.* 2012, p.784). The risk of violence amongst those with ASPD is particularly high, at around 12.8 times that of the general population (Yu *et al.* 2012, p.784). However, this is similar to the risk of violence amongst drug and alcohol abusers (Yu *et al.* 2012, p.784) who tend to receive less attention than the mentally disordered. Furthermore, the nature of the relationship between personality disorder and violence is unclear. The circularity of the ASPD diagnosis may mean that the association with antisocial behaviour is merely "trivial" or descriptive (Howard 2006). Furthermore, causality is difficult to establish due to the multiplicity of confounding factors affecting personality disordered offenders, including comorbid substance abuse and histories of comorbid mental illnesses and post-traumatic stress disorder (PTSD) (Duggan and Howard 2009).

Preventively detaining individuals on the grounds of a personality disorder diagnosis is difficult to justify in the absence of a clear causal link. This is compounded by the low predictive accuracy of actuarial risk assessment instruments when applied to individuals. Violent offending is a rare event, including amongst those with mental disorder, and has a low base rate (Szmukler 2003). The result is that actuarial instruments return a high number of both false positives (individuals identified as high risk who would not go on to be violent) and false negatives (individuals wrongly identified as low risk who would go on to be violent) (Szmukler 2003). It has been estimated that in order to prevent one violent act, six individuals in the DSPD category would have to be detained (Buchanan and Leese 2001). Even if the relationship between personality disorder and offending were more straightforward, the limited evidence for the effectiveness of the treatments on offer and the difficulties associated with demonstrating a reduction in risk in high security settings may be expected to result in long stays in preventive detention and little progress for the DSPD group. This has long been the experience of both prisons and secure hospitals in relation to high risk personality disordered prisoners and patients and one that the DSPD programme appears to have perpetuated.

6. Part I: Policy and Practice Governing Dangerous Offenders with Severe Personality Disorders

The first part of this thesis will examine the reasons for the seeming failure of the DSPD programme to meet expectations and question whether the programme can be rightly accused of deliberately holding back prisoners and patients the government is too afraid to release. It will also examine the basis for the reforms to the DSPD programme under the OPDP and question whether the decision to focus on treatment provision in prison brings us any closer to resolving the longstanding dilemmas presented by offenders with personality disorders.

(a) Reconstructing the story of the DSPD Programme and the OPDP

Drawing inspiration from the work of Ian Loader (2006) on the "platonic guardianship" that characterised penal policy-making in the mid-20th century, the first half of the thesis develops a "critical reconstruction and reinterpretation" (Loader 2006, p.561) of the

origins of the DSPD proposals and the implementation and evaluation of the DSPD programme. It also draws inspiration from Harry Annison's "interpretive political analysis" of the "story" of the IPP sentence and the "lessons" it holds for understanding penal politics and policymaking (Annison 2015, p.3; p.28). The DSPD "story" will help to shed light on the nature of political and institutional responses to the dilemmas posed by personality disordered offenders and the continuing influence of historical approaches to the management of dangerous individuals. It will also draw out the lessons to be learned from the DSPD "experiment" for future policymaking in this difficult area.

Together, the first three chapters of the thesis weave a story that reflects the "struggles" and "messiness" of the history of penal policy, which cannot be reduced to "a succession of clearly defined periods, each unified by a distinct dominant ethos" (Loader and Sparks 2004, p.15). In building this account, the research draws on a broad range of contemporary policy documents, the reports and minutes of evidence of committees of inquiry, parliamentary debates, newspaper articles, and descriptive and outcome studies of the DSPD programme and related initiatives. The evidence and insights gathered from these documents are supplemented by a select number of interviews conducted by the author. Those interviewed include some of the policymakers involved in formulating and promoting the DSPD and OPDP proposals and putting the plans into action, a number of academics who gained insider knowledge of the workings of the DSPD programme as independent evaluators, and some of the practitioners responsible for setting up and running the DSPD units in prisons and secure hospitals. Seventeen individuals were interviewed in total and the final sample was made up of seven practitioners, five policymakers (civil servants or politicians) and five academics.

The aim of gathering the interview data was not to present a set of empirical findings but rather to use interviewees' accounts to guide the research process, to aid in the interpretation of pertinent events and to gain insights into the workings of policymaking and practice not readily available from documentary sources. Insights from interviewees are woven throughout the thesis and quotations are cited along with the group to which they belong (practitioner, academic, civil servant or politician). Interviewees were given

assurances of anonymity, and the categories are accordingly broad so that individuals are not easily identifiable in a small field.

The story reconstructed from documents and interviewee accounts is critically evaluated in light of the history of efforts to deal with these difficult individuals, what was known about their clinical characteristics and their amenability to treatment. This approach exposes the assumptions underlying the proposals and the ideologies that influenced the plans and opens them up to critique. It will be argued in this thesis that rather than a "populist law and order reaction" (Mullen 2007, s.3) to a handful of high profile cases, the DSPD initiative was an attempt to respond to long-standing problems within the criminal justice and health systems given greater impetus by a perceived need to "do something" in response to public concerns. In seeking to break with the failures of the past, however, those behind the initiative disregarded some important lessons and developed unrealistic expectations of what it could achieve.

(b) Analysing inclusive and exclusionary approaches to personality disordered offenders

Much has been written on the DSPD initiative from the point of view of psychiatrists and other practitioners in the mental health field. There are few criminological studies tackling the issues raised by this controversial development and those that do exist tend to concentrate on the exclusionary character of the DSPD initiative and the proposals for preventive detention. Less regard has been had to the important aim of reintegrating personality disordered offenders into society and the claim that the provision of treatment could "balance" their rights against those of the public. This thesis aims to fill this gap by presenting a critical analysis of the inclusive or "progressive" elements of the DSPD proposals, the subsequent DSPD programme and the OPDP. This will allow for the elaboration of a more comprehensive understanding and critique of the normative justifications put forward for these developments.

Previous criminological critiques of the DSPD initiative and the DSPD programme have focused on interpreting and explaining the initiative in light of trends in penal policy, political ideologies and theories of punishment. In particular, analyses have drawn on the concept of "governmentality" inspired by the work of Michel Foucault (1977; 1979)

and continued by influential criminological theorists, including David Garland, Nikolas Rose and Pat O'Malley.

Drawing on the work of Pat O'Malley, Toby Seddon argues that the key to understanding the DSPD initiative is to view it in a "substantively political light" (O'Malley 1999, p.189, quoted in Seddon 2008, p.309). Seddon sees DSPD as a "hybrid" development that signifies a "coupling together of a novel focus on risk with a more archaic concern about dangerous subjects" (Seddon 2008, p.301; p.309). Although he acknowledges its "progressive" elements, Seddon's analysis of DSPD policy and practice focuses particularly on its exclusionary aspects. For Seddon, as personality disorder "is essentially an unchanging characteristic" "the perceived causal link between their personality traits […] and their potential for serious violence" marked those in the DSPD group as "'monsters' requiring an exclusionary response" (Seddon 2008, p.309). In the 1999 proposals, however, personality disorder and dangerousness were conceived as potentially mutable qualities. This casts doubt on Seddon's characterisation of DSPD as a set of unchanging characteristics that "*are* the person" (Seddon 2008, p.309). Furthermore, the salience of enhancing offender wellbeing or welfare suggests that there is more to the DSPD initiative than social or spatial exclusion. There is therefore a need to look beyond "dividing practices" to the assumptions underlying the "hybrid" exclusionary and inclusive approach of the DSPD initiative.

The limitations of Toby Seddon's account may be partially attributed to the theoretical framework adopted by his book *Punishment and Madness* (Seddon 2007) which draws on Michel Foucault's theory of "dividing practices":

> Essentially "dividing practices" are modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion – usually in a spatial sense, but always in a social one. (Rabinow, 1984, p.8, quoted in Seddon 2007, p.14)

For Seddon, the pseudo-science was the creation of the category of DSPD, a "neologism that has no legal or medical status" (Seddon 2007 p.139, quoting Farnham and James 2001, p.1926). By focusing on the spatial and social exclusion of dangerous "monsters", Seddon's compelling analysis misses out the centrality of treatment and social re-integration to the DSPD scheme. By contrast to Seddon, Leon McRae focuses on the

inclusive aspects of programmes such as the DSPD initiative and sees them as a form of "discipline" through which offenders absorb norms and come to engage in "pro-social behaviour" that is "self-regulating" (McRae 2013, p.67). McRae's explicitly Foucauldian lens underplays the survival of competing rationalities left over from earlier eras, however, that conflict with the claim that a "loss of faith in the capacity of psychiatric experts to reform offenders" has resulted in "increasingly pessimistic modes of crime control" (McRae 2013, p.53).

Fergus McNeill and colleagues argue that empirical studies of the practice of punishment have revealed a "governmentality gap" between macro-level accounts of "penal transformation and reconfiguration in late modern western societies" (McNeill *et al.* 2009, p.420) and the realities of "frontline" penal practices and discourses (McNeill *et al.* 2009, p.421). In their view, empirically-grounded accounts of punishment "may be best understood not as a counter-example to accounts of penal transformation but as evidence of an incompleteness in their analyses" (McNeill *et al.* 2009, p.420). It will be argued in this thesis that the DSPD story demonstrates that broad trends identified in macro-studies of penal "rationalities and technologies" (Garland 1997, p.174) such as the rise of "actuarial justice" (Feeley and Simon 1992), the supposed decline of the rehabilitative ideal (Garland 2001) and policies of expressive punitiveness (Pratt 2007) are "braid[ed]" (Hutchinson 2006, p.460) together with older strategies such as penal welfarism (Hannah-Moffat 2005) and governing criminal characters (McNeill 2009). By focusing on the claim of the DSPD initiative to pursue the social reintegration of the dangerous personality disordered offender, the present work will further interrogate the gaps between "dystopian" (Zedner 2002) accounts of the official abandonment of welfarism and the evidence for its survival in both policy and practice.

(c) Finding the dangerous and disordered subject

Andrew Rutherford has described the DSPD initiative as an example of the "vigorous renaissance of positivism towards offenders" (Rutherford 2006, p.51). As noted previously, the underlying premise of the DSPD proposals was that the risks the DSPD group posed to others "result[ed] from their disorder" (Home Office and Department of Health 1999, p.12). This implied a causal connection between personality disorder and offending and seems to align with a view of the DSPD offender as a dangerous "alien other" (Garland 1996, p. 461) who must be segregated from the normal population. On

the other hand, the psychological and behavioural therapies deployed by the DSPD programme and its successor, the OPDP, operate under the assumption that offenders can be taught how to manage and reduce their own risk of recidivism "by acquiring the requisite skills, abilities, and attitudes needed to lead a pro-social life" (Hannah-Moffat 2005, p.42). The "transformation of the risky subject into a prudent and rational risk managing subject" (Hannah-Moffat 2005, p.34) through rehabilitative intervention conflicts with conceptions of the DSPD offender as an intractable "monster" (Seddon 2008, p.309).

The majority of those detained in the DSPD units have been judged to be criminally responsible (Trebilcock and Weaver 2010a). However, the use of preventive detention with this group and scientific conceptions of the personality disordered offender as someone who has difficulty exercising control over his behaviour sit uneasily with the "classical" legal conception of the offender as a rational actor who freely chooses to commit crime and therefore deserves to be punished for it (Bottoms 1977). The seemingly conflicting conceptions of the personality disordered offender deployed by law, policy and practice require further investigation with a view to unearthing the assumptions underlying the current framework governing this group. This approach will inform the normative critique undertaken in the second half of this thesis.

7. Part II: Dangerous Offenders with Severe Personality Disorders and the Legal Framework

Building on the analysis presented in the first part of the thesis, the second half aims to develop a clearer picture of how personality disordered offenders who are considered dangerous are dealt with in the criminal justice and mental health systems. It will also develop a critique of the proposition that rehabilitation can serve as a limit on the use of preventive detention, seen in both the DSPD initiative and in subsequent case law from the European Court of Human Rights (ECtHR). By taking into account criminological and sociological insights into the practice and experience of punishment it will be argued that rehabilitation is not a sufficient brake on the disproportionate punishment of the DSPD group. This is because the delivery of rehabilitative treatments in a coercive environment is likely to increase the "hard treatment" experienced by prisoners.

Furthermore, the detention of the DSPD group on the grounds of risk in prisons and secure hospitals may be experienced as a punitive deprivation of liberty despite its preventive intentions.

(a) Reconstructing the legal framework

In reconstructing the interactions between law, practice and policy, the second half of the thesis draws on policy documents, insights from interviewees, evaluations of the DSPD programme and related interventions and relevant case law and legislation. A socio-legal methodology is adopted and the research seeks to interrogate the effects of the combination of law, policy and practice on personality disordered offenders and evaluate its appropriateness in light of their clinical characteristics. The work draws on the approach taken by Jill Peay in incorporating insights from psychology and psychiatry to analyse the many "awkward questions" personality disordered offenders pose for the law (Peay 2011a) and the relationship between mental disorder and crime (Peay 2011b). It is also inspired by Nicola Lacey's (2016) socio-historical analysis of criminal responsibility and Lucia Zedner's (2016) proposition that criminological insights into the subtle workings of penal power can be usefully combined with normative theory to trace boundaries around state punishment. This methodological approach opens up the possibility of creating a normative framework that can respond to the particularities of the personality disordered offender and protect against the risk of harsh treatment presented by current structures.

(b) Human Rights

(i) Preventive detention under the ECHR

Previous critical legal analyses have focused on the question of whether the DSPD proposals were human rights compliant and Nigel Eastman (1999a) notably voiced the concern that the plans were a means of circumventing the ECHR. Personality disordered offenders have long been included within the remit of mental health law, however, first under the rubric of "moral defectives" in the Mental Deficiency Act 1913 and then under the "psychopathic disorder" category in the MHA 1959 and the MHA 1983. In addition, as highlighted by Jill Peay, the ECHR presents few barriers to the use of preventive detention for those of unsound mind, provided the criteria in *Winterwerp v. the Netherlands* [1979] ECHR 4 are fulfilled (Peay 2011a, p.242). Indeed, the ECtHR

has acknowledged that the Convention has no equivalent to the treatability criterion in the MHA 1983 (*Hutchison Reid v. UK* [2003] ECHR 94). This sets a more lenient standard than the new "appropriate medical treatment test" introduced by the MHA 2007.

In this thesis, it will be argued that the concept of "treatability" continues to play a role in relation to personality disordered offenders despite the reforms introduced by the MHA 1983. Following the recent landmark decision of the Court of Appeal in *Vowles*, treatability acts as a double-edged sword. A narrow conception of treatability is deployed in order to prioritise punitive outcomes for personality disordered offenders at sentencing while a broad interpretation is used to facilitate their detention in hospital to protect the public. Given that their disorders affect their ability to exercise control over their impulses and act towards others "in the spirit of brotherhood" (Peay 2011a, p.232), it will be argued that this focus on punitive outcomes and reliance on rehabilitation as a limit on the use of preventive detention largely fails to provide an adequate response to the emotional and volitional deficits of personality disordered offenders.

The case law of the ECtHR also presents few barriers to the preventive detention of dangerous offenders in the prison system. The Court has approved the use of life sentences passed in order to protect the public from dangerous offenders even where the sentence would otherwise constitute disproportionate punishment in violation of Article 3 ECHR (*Weeks v. UK* [1987] ECHR 3). It is notable that the downfall of the IPP sentence before the ECtHR was not due to the risk of disproportionate punishment presented by short tariff IPP sentences but rather due to the government's failure to provide the rehabilitative interventions that the prisoners needed to progress towards release (*James, Wells and Lee v. UK* [2012] ECHR 1706). The potential for rehabilitation to provide a safeguard against the overuse of preventive detention may be questioned in the DSPD context, however, in light of the limited evidence base for the effectiveness of interventions in reducing risk.

(ii) A right to security and a duty to engage in rehabilitation

As noted previously, the DSPD proposals sought to "balance" the right of the public to be protected from dangerous offenders against the right of the offender not to be subjected to disproportionate punishment or arbitrary detention. The existence of a

"right to security" is controversial and has the potential to undermine human rights guarantees (Lazarus 2007; 2012). It has also been suggested that offenders serving indeterminate sentences have a "right" of access to rehabilitation under the ECHR (Van Zyl Smit *et al.* 2014). Building on Peter Ramsay's argument that "the reflex of a citizen's 'right to security' is the duty to reassure others of your good intentions" (Ramsay 2012c, p.146) it will be argued in this thesis that rather than having a "right" of access to rehabilitation, offenders who are presumed dangerous due to a personality disorder instead have a "duty" to engage with rehabilitation. This is because, building on the work of Mark Neocleous, the security of the public, and of the state, takes precedence over the liberty of the offender.

(c) A normative analysis of punishment and detention

While Toby Seddon (2008) acknowledges the tendency of criminological analyses of risk-based developments in penal policy to predict seemingly inevitable "dystopian" futures without offering a means of reversing destructive trends (Zedner 2002), his own account does not engage much further with the normative claims put forward in support of the DSPD initiative. Andrew Rutherford, on the other hand, analyses the DSPD proposals in terms of the exclusion of dangerous offenders and links the development to the "renaissance" of positivist criminology and a retreat from the retributivist "just deserts" model of punishment, which emphasises proportionality in punishment (Rutherford 2006, p.85). While implicitly preferring the idea of proportionate punishment, Rutherford does not offer a suitable response to the "legitimate anxieties" identified by Seddon that the DSPD initiative aimed to address.

The normative limitations of the accounts presented by Seddon and Rutherford may be attributed to their theoretical roots in Foucault's concept of "governmentality". According to David Garland, the "governmentality" literature in criminology:

> Aims to anatomize contemporary practices, revealing the ways in which their modes of exercising power depend upon specific ways of thinking (rationalities) and specific ways of acting (technologies), as well as upon specific ways of "subjectifying" individuals and governing populations. It also problematizes these practices by subjecting them to a "genealogical" analysis – a tracing of

> their historical lineages that aims to undermine their "naturalness" and open up a space for alternative possibilities (Garland 1997, p.174).

As the law is conceived as a "technology" of power in the Foucauldian lens, accounts drawing, implicitly or explicitly, on the concept of "governmentality" are less concerned with normative questions such as the source of the state's legitimacy to govern and how its powers should be limited (Ramsay 2012a, p.7; Zedner 2016, p.7). Rather, the aim of the governmentality literature is to expose the workings of systems of social control and to open up space for power to be contested and resisted (Rose 1996; 2000). The governmentality literature offers a useful means of deconstructing the legal framework governing the DSPD group and revealing "how far punishment is the exercise of state authority or governmental power" (Zedner 2016, p.7). However, the scepticism of the Foucauldian approach to normative questions means that it offers limited tools for developing a normative framework that responds to the rights, interests, and clinical characteristics of personality disordered offenders.

Normative theorising in relation to the criminal law is dominated by legal and penal theory in the philosophical tradition (Lacey 2016; Zedner 2016). According to Tadros, the "liberal understanding of power", which "opposes the areas controlled by social and state power to a space of freedom", fails to account for the "multiplicitous operations of power" identified by Foucault (Tadros 1998, p.77). Forms of punishment that fall outside the bounds of liberal conceptions of the criminal law and the exercise of state power therefore escape the normative constraints of the liberal philosophical tradition. This literature is also limited by its focus on "censure and sanction" as the fundamental elements of punishment (Zedner 2016, p.6).

Coercive measures taken by the state against individuals that are not officially designated as sanctions and do not involve the expression of censure can nevertheless be punitive in their effects and therefore deserve the scrutiny of normative theory (Zedner 2016). Detention in hospital at the end of a prison sentence, for example, is not officially designated as a form of punishment but it is likely to be experienced by the individual detained as an extension of the punitive deprivation of liberty imposed at sentencing. Similarly, the portion of a life sentence that follows the expiry of the tariff is intended to be preventive rather than punitive but it is served in the punitive prison

environment. Thus, extended detention on the grounds of risk to the public is likely to be experienced as punitive but may escape notice by legal and penal theorists.

Leon McRae's (2013; 2015) work on dangerous personality disordered offenders combines an explicitly Foucauldian analysis of rehabilitative practices with a normative analysis of sentencing structures and mental health legislation and case law. However, the latter is limited by a focus on the implications of sentencing reforms for the effectiveness of rehabilitative interventions. McRae argues that the abolition of the IPP sentence and its replacement with determinate sentencing structures threatens the effectiveness of personality disorder treatment by the removing the "legal coercion" acting on prisoners that induces them to cooperate with rehabilitative interventions in order to meet parole requirements (McRae 2013, p.66). This analysis neglects the larger normative question posed in this thesis of whether personality disordered offenders *should* be coerced into accepting rehabilitative treatments. The histories of trauma, neglect and deprivation common to personality disordered offenders make them vulnerable to re-traumatisation by psychological interventions conducted in the prison environment (Genders and Player 2014; Jones 2015). Furthermore, current rehabilitative interventions may be characterised as re-moralising and communicative of censure (Robinson 2008), raising the possibility that such interventions constitute additional punishment.

By combining the strengths of the criminological and liberal philosophical approaches to punishment, methodological approaches that fuse legal and penal theory with criminological insights "have significant potential to limit state power by identifying where punishment's boundaries ought to lie" (Zedner 2016, p.7). By adopting this approach, this thesis draws attention to the extent of the coercion acting upon personality disordered offenders judged to be dangerous and calls into question the potential for "preventive" detention combined with rehabilitative opportunities to "balance" the rights of the public against those of the individual.

(d) A socio-historical analysis of criminal responsibility

Previous analyses of the role of the law in the DSPD initiative tend also to focus on its exclusionary aspects. Andrew Rutherford saw the DSPD proposals as an example of Nikolas Rose's (2000) "risk thinking" in which the "excluded are not merely cast out

but become subject to strategies of control" and measures are taken to "neutralise" those who for whom "social inclusion" is "impossible" (Rutherford 2006, p.82). Within these "exclusionary circuits" "a whole variety of paralegal forms of confinement" are devised for those who appear "intractably risky" and "may require waiving the rule of law" (Rutherford 2006, p.82, quoting Rose 2000, p.333-334). Similarly, Toby Seddon and Bill Hebenton (2009) saw the DSPD initiative as an example of "counter-law" deployed to circumvent traditional legal safeguards that were seen to present barriers to the pre-emption of harms.

The concept of "counter-law" requires further examination in light of the legal framework that has come to govern the personality disordered group. The story of the DSPD programme shows that existing legal structures were flexible enough to allow the DSPD group to be detained in hospital even before the removal of the treatability criterion from the MHA 1983 (Trebilcock and Weaver 2010a). Furthermore, forms of subjective capacity-based criminal law with their attendant due process guarantees are not the only forms of "law" currently in operation. Liability for defective criminal character significantly pre-dates and continues to co-exist alongside these more "liberal" forms of criminal law (Lacey 2001a; 2001b; 2011; 2016).

Liberal criminal law theory's emphasis on capacity and moral culpability as the basis for criminal responsibility means that it has difficulty accounting for the survival of forms of criminal responsibility based on liability for defective criminal character (Lacey 1987). Rather than characterising forms of law that do not fit with liberal criminal law theory as "counter-law", a more productive approach is to view the law in its socio-historical context. For Lacey, such an approach opens up the possibility of seeing "the contingency of particular legal arrangements" and "the role, function and characteristics of criminal law as a form of power in modern societies" (Lacey 2016, p.12). Rather than something to be dismissed as an anomaly that is out of step with principles such as the rule of law, attention must be paid to the claims of forms of character and risk-based responsibility (Lacey 2016) to fulfil the social function of protecting the public from danger.

The analysis presented in this thesis also exposes the problematic nature of systems that combine both retributive and consequentialist principles and allow for individuals categorised as "dangerous" to be punished both for their past crimes and the risks of

future danger they pose. The exploration of the historical relationship between character, punishment and "reform" presented in this thesis will also serve to highlight the coercion underlying attempts at the rehabilitation of personality disordered offenders within the criminal justice system. The coercive or punitive nature of rehabilitative interventions with personality disordered offenders may also undermine their effectiveness, leading to increased use of preventive detention and increasing punishment.

8. The Significance of the Research

This thesis presents an in-depth, up-to-date and comprehensive critique of the law and policy governing personality disordered offenders that builds on and expands previous analyses, particularly the work of Jill Peay (2011a; 2011b; 2014; 2015; 2016). In addition, the thesis makes a significant contribution to developing an understanding of the under-researched interactions between sentencing decisions, selection for the DSPD programme or OPDP and the administrative processes of managing offenders in prisons and secure hospitals. It highlights the degree to which control has been extended over personality disordered offenders through administrative means and the pitfalls of relying on rehabilitative treatment as a means of limiting preventive detention. These insights have relevance to "dangerous" offenders beyond the DSPD group.

The thesis contributes to a growing literature on forms of "preventive justice" (Ashworth and Zedner 2014) in which rights are increasingly "securitised" (Lazarus 2012) in a fundamental state of public "insecurity" (Ramsay 2012a). It also traces the contours of a form of "late-modern rehabilitation" (Robinson 2008) that has perhaps more in common with Victorian approaches to reforming criminal characters (see Lacey 2011; 2016; Garland 1985) than the literature on macro-level trends in penal policy acknowledges. The research presented here also demonstrates the continuing influence of penal rationalities left over from the earlier "era" of "penal-welfarism" which was "animated by the practice of classifying and treating offenders in order to return them to the fold of citizenship" (Loader and Sparks 2004 p.6-7). Furthermore, it highlights the coercion underlying seemingly "liberal" (Moore and Hannah-Moffat 2005) criminal justice policies. Finally, it puts forward some suggestions for a normative framework

that can better respond to the particularities of the personality disordered offender and avoid the risk of disproportionate punishment presented by the use of preventive detention and rehabilitative interventions in the current system.

9. Thesis Outline

Part I: Policy and Practice in Relation to Dangerous Offenders with Severe Personality Disorders

Chapter 2: The Origins of Dangerous and Severe Personality Disorder

This chapter traces the origins of the DSPD initiative. It is argued that the policy was not merely a law-and-order reaction to one or two "high profile cases" but rather an attempt to respond to the long-standing problems presented by personality disordered offenders. This was given greater impetus by a perceived need to "do something" in response to public concerns. The "hybrid" (Seddon 2008) nature of the DSPD initiative may be partly explained by its interdepartmental roots, as early policymakers sought to marry together the objectives of the Home Office and Department of Health. The proposals also sought to strike a "balance" between the right of the offender to liberty and the purported "right" of the public to protection from dangerous offenders. The resulting compromise had a progressive or liberal appearance and was heavily dependent on the discovery of treatment and management techniques that would both reduce the distress of the DSPD group and help them to progress towards release. It also demonstrates the continuation of the rationales that underpinned the penal welfare era and highlights the coercion underlying the pursuit of rehabilitation.

Chapter 3: The Pilot DSPD Programme

Early assessments of the DSPD programme were disappointing, particularly in terms of the number of treatment hours inmates received and their slow movement through the system. In this chapter it is argued that the programme was not a cynical exercise in "warehousing" dangerous prisoners (Tyrer *et al.* 2010, p. 97), however, but rather that a combination of factors, including unrealistic expectations, operational issues, the characteristics of the patient group, and the premature commissioning of evaluations, led to an appearance of "warehousing" despite a commitment to treatment. On the other

hand, the programme also performed a risk monitoring function that could operate to hold patients and prisoners back where treatment did not reduce the risks they posed.

Chapter 4: The Offender Personality Disorder Pathway

At first, the OPDP appears to be a more concerted effort to follow through on the original aims and methods of the DSPD programme. On closer examination, however, it emerges that the plans for the OPDP appear to uncouple the goal of enhancing wellbeing from that of reducing risk. Nevertheless, the OPDP continues to accommodate more holistic treatment approaches that target the causes of personality disorder. In this sense, the OPDP remains ambivalent towards the nature of personality disordered offenders and does not seem much closer to resolving the dilemmas that led the early DSPD policymakers to propose a separate system. The analysis presented in this chapter sets the scene for a consideration of the implications of the OPDP and the current legal structure for the human rights and civil liberties of personality disordered offenders in the second half of the thesis.

Part II: Dangerous Offenders with Severe Personality Disorders and the Legal Framework

Chapter 5: Dangerous Personality Disordered Offenders in the Criminal Justice System

This chapter examines the complex web of sentencing provisions and administrative rules that have come to govern personality disordered offenders in the criminal justice system. The increasing use of indeterminate and lengthy determinate sentences, supervision requirements and civil preventive orders with dangerous offenders all point towards a revival of liability for defective criminal character. In the case law of the ECtHR, the public's "right to security" (Lazarus 2007; 2012; Ramsay 2012a; 2012b; 2012c) takes precedence over the offender's "right to rehabilitation" (Van Zyl Smit *et al.* 2014). It is argued that, instead of having a "right to rehabilitation", offenders who are presumed dangerous due to a personality disorder have a "duty" to engage in treatment. The priority given to the "right" of the public to security over the rights of individual offenders suggests that liberalism pursues "security" over liberty (Neocleous 2007). In this context, rehabilitation emerges as a means of rendering the coercive practice of preventive detention more palatable for liberal governments (Loader 2006).

Chapter 6: Dangerous Personality Disordered Offenders in the Mental Health System

This chapter examines the application of mental health legislation to individuals in the personality disorder category. Access to defences and pleas on the grounds of mental disorder, including unfitness to plead, insanity and diminished responsibility, is particularly limited for personality disordered offenders due to the focus on cognitive rather than volitional deficits. Following the decision of the Court of Appeal (CA) in *Vowles*, prison sentences are to be prioritised for personality disordered offenders, who are judged to be unsuitable for hospital disposals due to the dubious "treatability" of their disorders. Conversely, a broad understanding of treatability is used to allow the detention of personality disordered offenders in hospital on the grounds of risk. The result is that personality disorder operates as a double-edged sword in the service of punishment and the protection of the public. Furthermore, detention in hospital at the end of a determinate prison sentence may be understood as an extension of punishment.

Chapter 7: The Role of Rehabilitation in the Management of Dangerous Severely Personality Disordered Offenders

In this chapter it will be argued that neither classical nor positivist theories of punishment on their own can provide an adequate explanation for the contradictory conceptions of the personality disordered offender deployed by law, policy and practice. It is suggested that the concept of responsibility for defective criminato l character described by Nicola Lacey (2001a; 2001b; 2011; 2016) may provide a means of reconciling judgments of criminal responsibility with the use of preventive detention. This also provides an explanation for why the personality disordered offender must engage in rehabilitation in order to secure his release. Any proposals to reform the system would have to take into account the risks the delivery of rehabilitative interventions in coercive settings poses to the wellbeing of personality disordered offenders and the prospect of disproportionate punishment arising from the use of preventive detention. Attention must also be paid, however, to the symbolic nature of efforts to reassure the public that they are protected against those who provoke fear.

Part I: Policy and Practice Governing Dangerous Offenders with Severe Personality Disorders

Chapter 2: The Origins of Dangerous and Severe Personality Disorder

1. Introduction

The first half of this thesis, beginning with this chapter, traces the origins and subsequent development of the Dangerous and Severe Personality Disorder programme and its successor, the Offender Personality Disorder Pathway. In this chapter it will be argued that the DSPD initiative was more than a "populist law and order" (Mullen 2007) response to a group of dangerous "monsters" (Seddon 2008). The initiative emerges as the latest in a line of failed attempts to deal with longstanding problems, including the premature release of dangerous offenders from prison and the unproductive "custodial" care given to personality disordered offenders in the health system.

Furthermore, it will be argued that the DSPD proposals cannot be characterised as a means of disguising the preventive detention or "warehousing" of troublesome offenders (Tyrer *et al.* 2010, p.97). Instead, the plans sought to marry together health and criminal justice aims and to "balance" the interests of the public against those of personality disordered offenders (Home Office and Department of Health 1999). This arrangement depended heavily on the development and provision of treatment and management techniques that would improve the mental health of the DSPD group and reduce the risks they posed so that they could eventually be reintegrated into the community. Nevertheless, it was clear that the right of the offender to liberty would be subordinate to the purported right of the wider public to be protected from harm (Boateng and Sharland 1999). This calls into question the true nature of the "balance" being struck between competing interests. This theme will be returned to in the second half of this thesis.

2. The Advent of the DSPD Proposals

In several accounts, the immediate origins of the DSPD proposals are traced back to the arrest of Michael Stone in July 1997 and his subsequent conviction in October 1998 (Seddon 2008; Howells *et al.* 2007; Peay 2011b; Freestone 2005; Beck 2010;

Pickersgill 2012). Lin Russell and her daughters Megan, aged six, and Josie, aged 9, were brutally attacked with a hammer on a country lane in Chillenden, Kent on 9th July 1996. Lin and Megan were killed while Josie survived despite sustaining serious injuries. A psychiatrist and other staff who had treated Stone at a medium secure hospital unit contacted police after seeing a televised reconstruction of the murders and developing the view that Stone resembled the man sought by police (Francis *et al.* 2006, para. 21.1). Stone was arrested and subsequently tried and convicted of two counts of murder and one count of attempted murder and given three life sentences. A subsequent appeal against his conviction was rejected.[1] Michael Stone continues to maintain his innocence. The grounds for his conviction appear questionable as there was no forensic evidence tying him to the scene of the crime and he was convicted principally on the grounds of a confession made to a fellow prisoner.[2]

At the time of his trial for murder, Stone was presented in the media as a man who was known by mental health services to pose a danger to the public but who could not be detained because he was thought to be "too dangerous" or "untreatable" by psychiatrists (Francis *et al.* 2006). Some reports even stated that he had told doctors he had fantasies of killing children in the days before the attack and had begged to be admitted to hospital (Francis *et al.* 2006, Table 14.1). The later *Report of the Independent Inquiry into the Care and Treatment of Michael Stone* (Francis *et al.* 2006) exposed these and other claims as glaringly inaccurate. The Inquiry noted that while Stone posed problems of diagnosis and there had been some failings in his care, this was "emphatically not a case of a man with a dangerous personality disorder being generally ignored by agencies or left at large without supervision" (Francis *et al* 2006, p.5). Furthermore, the Inquiry stated that if Stone had indeed perpetrated the horrific crimes of which he had been convicted, it "found no evidence that they would have been prevented if failings in provision of treatment, care, supervision or other services to Mr Stone had not occurred" (Francis *et al* 2006, p.4).

[1] *R. v. Michael John Stone* [2001] EWCA Crim 297; *R (Michael Stone) v. CCRC* [2011] EWHC 3995.
[2] According to a website campaigning for Stone's release, the confession relayed by Damien Daly contained no more information than could have been gleaned from newspaper reports available at the time (see http://www.michaelstone.co.uk). Stone's application to the Criminal Cases Review Commission (CCRC) was rejected on the grounds that it was unlikely the Court of Appeal would admit new evidence from a witness claiming that Daly had told him eight years previously that he had lied in court. The High Court also rejected Stone's application for judicial review of the decision on the grounds that it was one the CCRC was entitled to reach.

Toby Seddon points to the Michael Stone case as having "raised concerns about the effectiveness of the penal and mental health systems in protecting the public" (Seddon 2008, p. 301-302). For other commentators, the Stone case provoked a "national political debate" on "the medical response to personality disorder" (Eastman 1999b, p. 206) and "ignited a war of words between the Home Office and the psychiatric profession" (Rutherford 2010, p.49). Martyn Pickersgill situates the Stone case in the broader context of "public fears about predatory paedophiles and serial killers" provoked by "media constructions of a dangerous individual abandoned by mental health professionals as a consequence of legal constraints" (Pickersgill 2012, p.6). Others saw the DSPD proposals more generally as a political response to public fears provoked by a handful of high profile cases (Mullen 1999; White 2002; Law Society 2000. See also Treasaden and Weller 2004, Eastman 1999a). These included the cases of Robert Oliver and Sidney Cooke, two paedophiles convicted of the manslaughter of 14 year old Jason Swift. Oliver was released in April 1998 after serving two thirds of a 15 year sentence and Cooke was released in September 1997 after serving 11 years. Their release caused public outcry and sparked off protests and vigilante attacks (BBC News 2013; BBC News 1998; Wainwright 1999).

Tony Maden, on the other hand, acknowledges that while "the announcement of a new service coincided with the conviction of a notorious offender, Michael Stone" "it is a mistake to attribute too much significance to this piece of political theatre" (Maden 2007, s.8). For Maden, the "true motivation" for the proposals "was not a single case but longstanding frustration within government at the refusal of psychiatrists to address the problem of high-risk offenders with personality disorder" (Maden 2007, s.8). Andrew Rutherford also points to earlier roots and argues that the Stone case did not prompt the development of the DSPD proposals but was a convenient "presentational" tool that provided "a narrative into which embryonic proposals might be located alongside the rationale and justification to carry them forward into the political arena" (Rutherford 2006, p.80). Rutherford points to the formation of a small group of officials drawn from the Home Office and Department of Health shortly after the election of the New Labour government in May 1997. The research presented in this thesis shows, however, that the origins of the proposals can be traced much further back.

The links made to the Stone case in the literature are not surprising given that then Home Secretary Jack Straw announced that he and the Minister for Health, Frank

Dobson, were "urgently considering" "changes in law and practice" in relation to dangerous mentally disordered offenders three days after Stone was convicted (HC Deb, 26 October 1998, col. 9W). In the House of Commons on 26 October 1998, A.J. Beith of the Liberal Democrats asked Straw whether he believed that "further measures" were "needed to deal with offenders who are deemed to be extremely violent because of mental illness or personality disorder, but whom psychiatrists diagnose as not likely to respond to treatment" (HC Deb, 26 October 1998, col. 9W). Beith explained that concerns had arisen not only following the conviction of Michael Stone but because there had been "a tendency in recent years for psychiatrists to diagnose a number of violent people as not likely to respond to treatment" (HC Deb, 26 October 1998, col. 9W). In response, Straw launched a public attack on the psychiatric profession for their perceived failure to deal adequately with dangerous patients:

> Quite extraordinarily for a medical profession, the psychiatric profession has said that it will take on only patients whom it regards as treatable. If that philosophy applied anywhere else in medicine, no progress would be made in medicine. It is time that the psychiatric profession seriously examined its own practices and tried to modernise them in a way that it has so far failed to do (HC Deb, 26 October 1998, col. 9W).

A further public attack was made on 8 December 1998 by Frank Dobson on the policy of "care in the community" introduced by the previous Conservative government. Dobson claimed that the policy had "failed" and its "failure to deal effectively with the most severe cases [...] [had] dealt a blow to all mental health efforts and lost the confidence of the public" (HC Deb, 8 December 1998, col. 145). Dobson informed the Commons that he and Straw were considering proposals "to create a new form of renewable detention for people with a severe personality disorder who are considered to pose a grave risk to the public" (HC Deb, 8 December 1998, col. 146).

Dobson's statement reflected the claims made in a White Paper entitled *Modernising Mental Health Services* published the same day (Department of Health 1998). As a hint of what was to come, the White Paper mentioned that proposals for the reviewable detention of personality disordered offenders were "likely to require the development of specialist programmes under conditions providing both appropriate security and interventions designed to reduce and manage risk" (Department of Health 1998, para.

4.32). It was also clear that "the safety of the public" would be "of prime concern" (Department of Health 1998, para. 4.33).

In July 1999, a Green Paper entitled *Managing Dangerous People with Severe Personality Disorder* appeared. The Paper described a small group of serious offenders suffering from severe forms of personality disorder who presented a risk to the public. "The overwhelming majority" of the DSPD group had "committed serious offences such as murder, manslaughter, arson, serious sex offences, or grievous bodily harm" (Home Office and Department of Health 1999, p.12). It was estimated that around 1,400 men in the DSPD group were detained in prison while about 400 were detained in psychiatric hospitals. A small group of between 300 and 600 men who were "generally well known to local police, health and social services because of their dangerous and demanding behaviour" but who had not been convicted of a recent offence were estimated to be abroad in the community (Home Office and Department of Health 1999, p.12). The numbers of women were expected to be much lower, later estimated at around 50 in total (DSPD Programme *et al.* 2006, p.8).

At the time the Green Paper was published, individuals in the DSPD category could not be detained beyond the prison sentence imposed for their last offence and could not be civilly committed to a psychiatric institution following the expiry of that sentence unless they were certified as suffering from mental illness, psychopathic disorder or mental impairment under the Mental Health Act 1983 (MHA 1983). "Psychopathic disorder" was defined as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" (former s.1(2) MHA 1983). Compulsory committal to psychiatric hospital on this ground was contingent on treatment being "likely to alleviate or prevent a deterioration of [the patient's] condition" (former s.3(2)(b) MHA 1983). As psychopathic disorder was considered untreatable by some psychiatrists, the "treatability" criterion was presented by the government as a stumbling block to the detention of these individuals in psychiatric hospital (Peay 2011b, p. 176).

"DSPD" was not a recognised clinical diagnosis but rather an administrative category describing a troubled and troubling group with multiple complex problems. In addition to posing a risk to the public upon release, the DSPD group were also described as

"highly disruptive" and were said to pose "significant management challenges in institutional settings" and a "constant threat" to staff and other inmates (Home Office and Department of Health 1999, p.12). They were also "adept at undermining management regimes" (Home Office and Department of Health 1999, p.12). This small group of offenders was not only portrayed as dangerous and disruptive, however, but also as distressed and in need of help for their disorders (Home Office and Department of Health 1999, p.49).

"Severe personality disorder" was defined in the 1999 Green Paper as an "inability to relate to others, poor control of impulses and difficulty in learning lessons from previous experience" (Home Office and Department of Health 1999, p.7). This definition did not appear in any diagnostic manuals but seemed to describe a particular subset of individuals diagnosed with antisocial or dissocial personality disorders. In addition, those in the DSPD group were said to be affected by high rates of substance misuse, suicide, depression, anxiety, illiteracy, poor relationships, unemployment and homelessness (Home Office and Department of Health 1999, p.48).

The 1999 Green Paper put forward two options for addressing the issues identified. Option A would retain the existing legal framework with some changes aimed at facilitating the preventive detention and extended supervision of the DSPD group. The treatability criterion would be removed from the MHA 1983 and there would be new powers for assessing prisoners on remand for DSPD and for the supervision and recall of DSPD patients following their release from hospital. Judges would be encouraged to make greater use of the discretionary life sentence with those identified as DSPD in order to avoid their premature release. On the operational side, specialist treatment facilities would be established within existing structures, those services already in place would be improved and joint working between the prison and hospital estates encouraged.

Option B went significantly further. It proposed the creation of a dedicated service for the DSPD group that would be separate from the existing prison and secure hospital systems. Individuals in the DSPD group would be detained and treated in the new facility under a "DSPD direction" available to courts ruling in criminal or civil proceedings. There would also be powers to supervise and recall those released from the new service into the community. Under this regime, the location of detention "would be

based on the risk that the person represented and their therapeutic needs rather than whether they had been convicted of an offence" (Home Office and Department of Health 1999, p. 5). Notably, and controversially, this indicated that detention could take place without the need for a criminal trial and conviction. Option B, also referred to as a "third service" or "Third Way" for the DSPD group (Fallon 1999, para. 7.12.1), was the preferred option of the ministers and civil servants behind the proposals.

3. Historical Approaches to Longstanding Problems

(a) Treatability in mental health law

A discussion was put forward in the 1999 Green Paper of the history of attempts to deal with problematic individuals similar to those in the DSPD group. This brief history began with the 1904 Royal Commission on the Care and Control of the Feebleminded which proposed that State care and control be extended to "moral imbeciles". These individuals were not easily categorised as "feebleminded" as their intellectual functioning was generally unimpaired but yet they were perceived to be "mentally defective" due to their propensity for antisocial behaviour. They were described as "absolutely devoid of all moral and altruistic feeling" and lacking in the "capacity for mental comparison and discrimination, for forming judgments, and for looking ahead" (Tredgold 1926, p.5). This group was eventually incorporated into the Mental Deficiency Act 1913 as "moral defectives, that is to say, persons in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities and who require care, supervision and control for the protection of others" (Mental Deficiency Act 1919, s.1(1)(d)).

In 1957, the Percy Commission on Law relating to Mental Illness and Mental Deficiency proposed the abolition of the category of moral defectives and the creation of a new category of "psychopathic patients". The Commission could not agree on a definition of psychopathic disorder, however, and consequently the Ministry of Health elaborated the following: "a persistent disorder of personality (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient". This became a ground for compulsory detention and treatment under the MHA 1959 (s.4(4)).

According to the Home Office in its Memorandum to the Home Affairs Committee examining the DSPD proposals, the inclusion of the "treatability criterion" in the MHA 1983 "marked a fundamental shift away from the previously-held view that the management and, where possible, treatment of people with psychopathic disorder […] was a legitimate function of the health service" (Home Office 2000, para. 6). However, it should be noted that "psychopathic disorder" was further defined in the MHA 1959 as a condition that "requires or is susceptible to medical treatment" (MHA 1959 s.4(4)). This stemmed from the recommendation of the Percy Commission that compulsory powers should not apply to adult psychopaths unless their behaviour was serious enough to bring them into conflict with the law and treatment was the most appropriate disposal (Fallon 1999, para. 6.1.18).

The inclusion of a treatability test in the MHA 1959 casts doubt on Jack Straw's claim in Parliament on 26 October 1998 that there had been a "change in the practice of the psychiatric profession which, 20 years ago, adopted […] a common-sense approach to serious and dangerous persistent offenders" (HC Deb, 26 October 1998, col.9W). Furthermore, Jack Straw's "common-sense" approach does not line up with the concerns of the 1961 Report of the Working Party on the Special Hospitals (Ministry of Health 1961). The Working Party was nervous of the implicit assumption in the MHA 1959 that psychopathic disorder *could* be treated and worried that the NHS would be forced to take on potentially large numbers of new patients whose care and treatment was problematic (see Fallon 1999, para. 6.1.24-28). This is in stark contrast with the concern of Straw's government that the treatability test was being used to exclude patients and demonstrates a change in the concerns of governments towards personality disordered patients.

The MHA 1983 retained the category of psychopathic disorder, defined in similar terms to the MHA 1959, but the explicit reference to treatability was removed. Instead, a subsection specified that detention in hospital would only be permissible in cases of psychopathic disorder or mental impairment where medical treatment was "likely to alleviate or prevent a deterioration in [the patient's] condition" (original MHA 1983 s.3(2)(b)). This clause was intended "to allow clinicians to discriminate between those who were and were not treatable and to protect patients from inappropriate detention in hospital" (Fallon 1999, para. 6.1.50).

(b) The Butler Committee and the reviewable sentence

The Butler Committee on Mentally Abnormal Offenders was established by the Home Office and Department of Health and Social Security (DHSS) in 1972 to investigate the criminal and mental health law applying to mentally disordered offenders, examine expert evidence and make recommendations. The Committee conducted its review in the wake of two high profile cases involving serious reoffending by two patients given conditional release from Broadmoor hospital. Graham Young, known as "The Teacup Poisoner", carried out further poisonings, and Terence Iliffe, who had seriously assaulted his former wife, went on to strangle his new wife (Bowden 1996). At their respective trials, both were found not to be suffering from mental disorder and were convicted and sentenced to prison (Butler 1975, para. 4.1).

In a review of the evidence that does not differ greatly from that conducted by the Fallon Inquiry (1999) almost 25 years later (see below), the Butler Report (1975) noted that the accuracy of clinical and actuarial predictions of reoffending by mentally disordered individuals was very limited. It also noted that there was not necessarily a link between dangerousness and mental disorder and individuals could remain dangerous even after their mental disorder had been successfully treated. The Committee also concluded that "the great weight of evidence" tended "to support the conclusion that psychopaths are not, in general, treatable, at least in medical terms" (Butler 1975, para. 5.34).

In their memorandum of evidence to the Butler Committee, the Home Office and DHSS drew attention to "the problem of the legal obligation to release, at the end of determinate prison sentences, a small number of men who are probably dangerous but who are not acceptable for treatment in hospital" (Butler 1975, para. 4.34). This indicates that interdepartmental work in relation to the dilemmas presented by the DSPD group had begun at least 24 years prior to the publication of the 1999 Green Paper. In response to this problem, the Butler Committee recommended the introduction of a reviewable sentence for dangerous offenders, defined as those with "a propensity to cause serious physical injury or lasting psychological harm" to others (Butler 1975, para. 4.10). The sentence would not be "punitive in intent but designed to enable the offender to be detained only until his progress under treatment […] [would] allow him to be released under supervision without serious risk to the public" (Butler 1975, para.

4.39). The sentence would be discretionary and reserved for offenders convicted of a list of offences which "had caused or might well have caused grave harm to others" (Butler 1975, para. 4.41).

In the view of the Butler Committee, the secure containment of psychopathic offenders was best carried out within the prison service. The Committee further proposed the establishment of prison "training units" for dangerous psychopaths that would allow suitable volunteers to take advantage of a structured regime and vocational training opportunities that would encourage the process of maturation and lead to their eventual release (Fallon 1999, para. 6.1.42). The Committee did not recommend the use of hospital as a place of preventive detention but it did support the use of hospital orders for psychopathic offenders where treatment in hospital could be expected to be of benefit to the patient.

The 1999 Green Paper commented that Butler's reviewable sentence proposals "were not really consistent with the stated aim of tackling future dangerousness" because the sentence could only be imposed where the individual had previously been convicted of an offence for which a life sentence was available (Home Office and Department of Health 1999, p.38). The new sentence never came to pass "because it appeared to add little to what could be achieved through the mechanism of the discretionary life sentence" (Home Office and Department of Health 1999, p.38). Furthermore, as the sentence would have been prospective in nature it would not have resolved the more immediate problem of the release of prisoners from determinate sentences. Thus the gap identified by the government remained and interdepartmental work on the issue of dangerous personality disordered offenders continued.

(c) Interdepartmental working groups

In 1986, a joint Home Office and DHSS working group was established to consider changes to the recently introduced MHA 1983 to deal with another problem presented by offenders suffering from psychopathic disorder. Here the concern was with restricted patients being discharged from special hospitals by Mental Health Tribunals where they were "no longer suffering from psychopathic disorder or no longer suffering from it to a nature or degree which made it appropriate for [them] to be liable to be detained in a hospital for medical treatment *but the public was nevertheless felt to be at risk*." (Home Office and DHSS 1986, para. 15(iii). Original emphasis). Again, this anxiety had been

provoked by a "small number of cases" (Home Office and DHSS 1986, para. 15(iii)). As highlighted by Jill Peay, the "theoretical legal lacuna" underlying this problem was that once an offender had been diverted into the hospital system and away from the penal system, his continued detention depended on the fulfilment of the terms of the MHA 1983. Consequently, "considerations of protective custody and retribution, either explicit or covert" could no longer play a part in decisions governing his release (Peay 1988, p. 69).

The Working Group put forward three legislative options. The first would have replaced the s.37 hospital order with a provision that would allow the court to sentence a mentally disordered offender to imprisonment but to direct that he be admitted directly to hospital. The second proposal was to remove the option of a hospital order for offenders with psychopathic disorder so that only a penal disposal could be given at sentencing with the option of a later transfer to hospital. The third would have confined the use of hospital orders to offenders with psychopathic disorder who would not have merited a restriction order. As noted by Peay (1988), if adopted, the proposals could have exposed the public to a greater level of danger. Unless courts were encouraged to make greater use of the discretionary life sentence, the removal of the hospital order option would entail greater numbers of psychopathic offenders being given determinate sentences and released without supervision while potentially dangerous. Responses to the consultation paper from professionals in the field were largely negative and the proposals were quietly dropped (Peay 1988).

The subsequent Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services, chaired by Dr John Reed (1992), led to the establishment of a Department of Health and Home Office working group on psychopathic disorder (Reed 1994). Reed commented in his evidence to the Fallon Inquiry that psychopathic disorder "was by far the most difficult topic he had taken on to review" (Fallon 1999, para. 6.1.75). It was a subject upon which it was "extraordinarily difficult […] to produce very positive conclusions" and "it had proved extremely difficult to get agreement on a wide range of issues" (Fallon 1999, para. 6.1.75). In sum, he concluded "we do not know what [the disorder] is caused by, we do not know how to measure it, we do not know what interventions are effective and we do not know very well how to measure the consequences of intervention" (Fallon 1999, para. 6.1.75).

It may come as no surprise that the principal recommendation of the Working Party's report was to instigate "a comprehensive programme of research" on interventions for the disorder (Home Office and Department of Health 1999, p. 38). However, it also put forward proposals for a "hybrid order" intended for psychopathic offenders of uncertain treatability not far removed from the first proposal of the 1986 Working Group. According to Jill Peay and Nigel Eastman, the hybrid order was conceived to "encourage psychiatrists to 'have a therapeutic go' in the knowledge that, should the offender prove untreatable, patient and doctor would not remain locked (literally) long term in a non-therapeutic relationship" (Eastman and Peay 1998, p. 96). The proposals led to the creation of the hospital and limitation direction, introduced into the MHA 1983 by the Crime (Sentences) Act 1997. This order, available under s.45A, allows offenders to be given a prison sentence but sent straight to hospital for treatment. The provision has been little used but may grow in importance following the guidance issued by the Court of Appeal in the recent case of *Vowles*, discussed in Chapter 6.

The joint memorandum of the Home Office and DHSS to the Butler Committee in 1975 and the establishment of the interdepartmental Working Group in 1986 demonstrate that officials from the Home Office and DHSS had been working together on longstanding problems in the decades prior to the publication of the 1999 Green Paper. This indicates that the controversial DSPD proposals have a long history that significantly pre-dates the Michael Stone case and even the election of the New Labour government in May 1997.

4. Concurrent Reviews

(a) The Fallon Inquiry

The Fallon Inquiry was appointed in February 1997 by Stephen Dorrell, then Secretary of State for Health under John Major's Conservative government. The remit of the Inquiry was to investigate allegations made by Steven Daggett, a former patient of the personality disorder unit (PDU) at Ashworth. These included "possible paedophile activity on one of the wards of the PDU, the availability of pornography, drugs and alcohol, and financial irregularities" (Fallon 1999, para. 1.1.1). The Inquiry was encouraged by both Dorrell and his New Labour successor, Frank Dobson, "to look

more widely than [its] relatively narrow brief to focus on matters of broad policy interest" (Fallon 1999, para. 1.2.3). As part of its broader task, the Inquiry examined in detail "the controversies surrounding the diagnosis, treatment and treatability of personality disorder and the right services for individuals with personality disorder" and focused particularly on "the severe end of the spectrum" (Fallon 1999, para. 1.2.3). In addition to hearing evidence from a number of witnesses, the Inquiry arranged seminars with experts on these broader issues and visited a number of specialist services in the UK, Holland, Germany and Switzerland.

The Report of the Fallon Inquiry summarises evidence from nine patients at the PDU. Overall, the patients' evidence "gave a sense of time passing with precious little progress" and "an atmosphere of inertia […] in which poor practice, apathy and corruption [could] flourish" (Fallon 1999, para. 1.25.34). The bulk of the clinical input into the patients' treatment at Ashworth was psychological, and this appeared to be standard practice with personality disordered patients. Some of the Inquiry's expert witnesses asserted in their evidence, however, that the diagnosis and assessment of patients remained the job of psychiatrists. This was because the psychologists were not trained to conduct medical assessments of patients and were not authorised to prescribe medication (Fallon 1999, para. 4.5.6 - 7). While the Inquiry recommended that the "input of clinical psychology to the PDU should be sharply increased" (Fallon 1999, para. 4.9.6) it also noted the limits of the psychologists' abilities, commenting that "the effectiveness of much of what they do is still under-researched" (Fallon 1999, para. 4.9.3).

In his account of the origins of the DSPD proposals, Andrew Rutherford argues that the Fallon inquiry raised the prospect that personality disorder could be treated by giving a voice to forensic psychologists who were optimistic about the contribution their skills could make. He also asserts that the conviction of Michael Stone was an important presentational tool that illustrated the urgency of the problems the government proposed to address (Rutherford 2006). For Rutherford, the scandals and inquiry at Ashworth and the arrest and conviction of Michael Stone were "events" that "gave shape and direction to the policy-making process" and "were, themselves, also shaped by it" (Rutherford 2006, p.64). The central role played by psychologists at Ashworth casts some doubt on Andrew Rutherford's (2006) assertion that the Fallon Inquiry allowed this professional group to rise to prominence, however. It is clear from Fallon that psychological

treatments were acknowledged to be the most appropriate interventions for personality disorder.

The attack Jack Straw launched on psychiatrists in the House of Commons on 26 October 1998 contrasted starkly with the deferential tone of the previous government. On the appointment of the Fallon Inquiry, Stephen Dorrell, then Secretary of State for Health, indicated that questions regarding the treatment of patients "suffering from long-term personality disorders" were being considered by the psychiatric profession and were "best dealt with in that context, as it is the clinicians who ultimately have to make the decisions about the treatment of individuals" (HC Deb, 10 February 1997, col. 24). In the same vein, Dorrell, while acknowledging the existence of "a serious question about the proper provision for people with severe personality disorders" suggested "that lay Members of this House should approach this question by taking the advice of trained psychiatrists, who have a proper understanding of what is and is not possible with modern psychiatric science" (HC Deb, 10 February 1997, col. 29). While psychologists already appeared to have a prominent position in practice, Jack Straw's interventions in Parliament demonstrate that the government had become frustrated with the scepticism of some psychiatrists and that it was looking to other professions for a more optimistic view on treatment. Straw emphasised that society "should not write anybody off" and "somebody may be deemed untreatable by a particular group of psychiatrists, but be susceptible to treatment by clinical psychologists, psychoanalysts or psychotherapists, or just within a therapeutic community" (HC Deb, 15 February 1999, col. 605).

The DSPD initiative cannot be characterised as stemming from a "loss of faith in the capacity of psychiatric experts to reform offenders" linked to "increasingly pessimistic modes of crime control (such as punitive sentencing)" (McRae 2013, p.53). Rather than shunning or breaking with expertise, the government wished to harness those experts who shared its optimistic stance on treatment. This is in contrast with the "new penology" that Jonathan Simon and Malcolm Feeley argue has come to replace the "old penology" which was concerned with reforming offenders (1992). The task of the new penology is "managerial, not transformative" (Feeley and Simon 1992, p.452). It seeks to "identify, classify, and manage groupings sorted by dangerousness" in order "to deploy control strategies rationally" rather than to "intervene or respond to individual deviants or social malformations" (Feeley and Simon 1992, p.452). The DSPD

initiative, however, had much loftier ambitions than mere classification and risk management. In the DSPD proposals, "dangerousness" and personality disorder were purposely constructed as potentially mutable qualities and the message was one of therapeutic optimism.

The DSPD story also illustrates a "turf war" between psychologists and psychiatrists that was well underway before the 1999 Green Paper appeared. The theme of professional rivalry between these two groups was raised by several interviewees. In the view of one civil servant involved in developing the DSPD proposals:

> The psychiatrists were much more powerful than the psychologists, and we sometimes did have a bit of a feeling that the psychiatrists were wanting to have their cake and eat it. That they wanted to maintain that managing and everything to do with this group of people was something for them rather than psychologists, but at the same time wanted to be able to say that there was no treatment you could give so they could say "no, go away".

Similarly, a practitioner remarked:

> Most psychiatrists would not have had anything to do with a personality disorder service. And that is a split that runs through the professions in a way because I think psychologists can see that this is a lot of work that they could do, a massive opportunity, whereas all psychiatrists could see was a problem, for all sorts of reasons. They were very negative about it.

It is clear from Fallon, however, that there was a range of views amongst psychiatrists and other mental health practitioners as to whether or not personality disorder could be treated. This indicates that the "split" was not necessarily along professional lines. One survey of forensic psychiatrists conducted in 1992 noted by the Fallon Inquiry found that about 10% of respondents "were totally dismissive of psychopaths and their treatability" while another 10% "stated equally vehemently that psychiatrists had a duty to treat this group of patients who caused suffering to themselves and society" (Fallon 1999, para. 6.6.4). The rest were "somewhere in between" (Fallon 1999, para. 6.6.4). The Inquiry heard evidence from psychiatrists who were optimistic about treatment "who deem[ed] it right never to give up, and never to stop trying" and others who believed that treatment may succeed with some personality disordered individuals but

not those at the more severe end of the spectrum (Fallon 1999, para. 6.65). It concluded that "there continues to be a wide diversity of opinion among experts from all the professions about the treatment and management of personality disorder and particularly severe personality disorder" (Fallon 1999, para. 6.10.1). However, it seemed that, due to a lack of robust empirical evidence, scepticism about the effectiveness of the range of treatments on offer at the time appeared to hold sway.

Although the 1999 Green Paper had yet to be published, the Fallon Inquiry considered the option of a "third service" for personality disordered offenders similar to that proposed in Option B. In the Inquiry's view, such a service would have a number of advantages. It would relieve prisons and hospitals of difficult individuals and be free from "the weight of history and accumulated failures" of both types of institution in relation to this group (Fallon 1999, para. 7.12.4). Furthermore, the units would present an opportunity for research and the development of clinical skills in treating personality disorder. Ultimately however, the Inquiry did not support the third service due to its potentially negative effects. These included additional bureaucracy and the likelihood of rivalry between the Department of Health and the Home Office over who owned the service. There were also concerns that the new service would be neither a "true healthcare service nor a proper penal one" (Fallon 1999, para. 7.12.9). The Inquiry also noted that the service had the potential to become isolated from the therapeutic mainstream and have difficulties in attracting good staff. Finally, it commented that "concentrating the most problematic people in the system could be a recipe for disaster" (Fallon 1999, para. 7.12.12). Several of these remarks appear prophetic in light of the problems that were to surface in the implementation of the DSPD pilot programme, discussed in the next chapter.

Like the government, however, the Fallon Inquiry was of the opinion that "doing nothing" about the problem of dangerous personality disordered offenders being released from prison "[was not] an acceptable policy" (Fallon 1999, para. 7.4.4). The Inquiry disapproved of the use of the MHA 1983 to effect preventive detention, expressing the view that "hospitals are not prisons" and "only those who are willing and able to benefit should be transferred to and remain in hospitals" (Fallon 1999, para. 7.2.1). Like the 1986 Working Group, it suggested that hospital orders should no longer be an option for personality disordered offenders and it also recommended replacing "psychopathic disorder" in the MHA 1983 with the less stigmatising term of

"personality disorder" (Fallon 1999, para. 7.6.8). The Inquiry also recommended the introduction of a reviewable prison sentence similar to that proposed by the Butler Committee. This sentence would be available where a life sentence was not and composed of a determinate tariff followed by the option to renew detention for up to two years at a time. Perhaps foreshadowing the introduction of the broader-based indeterminate sentence of imprisonment for public protection (IPP), introduced by the Criminal Justice Act 2003, the Fallon Inquiry commented that the government could choose to expand the application of the reviewable sentence to other "dangerous offenders" who did not suffer from personality disorder but who nevertheless posed "a substantial risk of causing harm to others after release from prison" (Fallon 1999, para. 7.5.7).

(b) The Richardson Committee

In October 1998, Ministers at the Department of Health appointed an Expert Committee to conduct a review of the Mental Health Act 1983, chaired by Professor Genevra Richardson. In its report, the Richardson Committee presented a vision of a new Mental Health Act based on the concept of capacity and the principles of patient autonomy, reciprocity, and non-discrimination (Department of Health 1999a). Under the scheme, a patient could be detained for treatment where he was found to be suffering from a mental disorder, broadly defined, that was sufficiently serious to require medical care and treatment under the supervision of specialist mental health services and where he lacked capacity to consent to such care and treatment. Treatment would not be imposed on the patient unless it was "necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation" and the treatment could not be delivered without compulsion (Department of Health 1999a, para. 5.95).

The Committee acknowledged that personality disordered patients, who in general retain capacity to make decisions regarding their care and treatment, would fall outside the scope of the proposed test (Department of Health 1999a, para. 4.15). To compensate for this gap, the Committee proposed that the autonomy of a mentally disordered patient with capacity could be overridden where there was "a *substantial* risk of *serious harm* to the health or safety of the patient or to the safety of other persons if s/he remains untreated" and where there were "positive clinical measures included within the

proposed care and treatment which [were] *likely* to prevent deterioration or to secure an improvement in the patient's mental condition" (Department of Health 1999a, para. 5.95. Emphasis added). The latter condition was akin to the "treatability" test in the MHA 1983. However, the "substantial risk" and "serious harm" requirements set a higher threshold than the civil sections of the MHA 1983, which merely required compulsory treatment to be "necessary for the health or safety of the patient or for the protection of other persons".

The Richardson Committee's concern for patient autonomy and reciprocity presented barriers to the risk-based detention of a group for whom there was a scant evidence base for treatment. Like the Fallon Inquiry's proposed reviewable sentence, which was prospective in nature, the Richardson Committee's proposals did not provide an immediate solution to the problem of dangerous offenders who had already been given determinate sentences. It may not come as a surprise, therefore, that the Committee's proposals were only accepted in part and separate plans were drawn up for the DSPD group.

5. Uniting Competing Rights and Interests

Drawing on insights from contemporary documents and interviews with some of those involved in the elaboration of the 1999 consultation paper, it will be argued in this section that the DSPD proposals were a response to long-standing problems given greater impetus by public concerns about the release of dangerous offenders spurred on by oftentimes inaccurate and sensationalist media reporting. The proposals were also a compromise between the priorities of the Home Office and Department of Health in relation to the DSPD group and aimed to strike a "balance" between the rights and interests of the public. Despite efforts to present the proposals in a liberal and progressive light, however, they were to prove highly controversial and radical plans for a "third service" for the DSPD group were eventually scaled back.

(a) A civil service initiative

Andrew Rutherford traces the proposals put forward by the 1999 Green Paper to the formation of "a small group of civil servants, drawn from the Home Office and the Department of Health" "within weeks of the Labour Party's election victory in May

1997" (Rutherford 2006, p. 52). No individual authors were named on the face of the paper but reference was made to a "joint working group of officials" established by Home Office and Health Ministers in the summer of 1997. The remit of this group was "to examine the position and make recommendations for changes in the legal and operational framework for managing dangerous severely personality disordered people" (Home Office and Department of Health 1999, p.10). The fact that the interdepartmental working group was formed so quickly after the May 1997 election indicates that its foundations had been laid in previous years. The working group may also be seen as carrying on a tradition of interdepartmental work on the problem of dangerous offenders that began as far back as 1975. According to interviewees, the working group was the initiative of a group of civil servants keen to continue the work of the Reed Review (1994) begun under the previous government. When it was time to brief incoming Department of Health and Home Office Ministers following the 1997 General Election, civil servants in both Departments sought to keep the issue of personality disordered offenders on the agenda.

Both the Fallon Inquiry and the Richardson Committee's proceedings were on-going while the interdepartmental working group were developing the DSPD proposals and there is evidence of exchanges between these bodies (Rutherford 2006). The Fallon Inquiry had early access to the plans for a third service for the DSPD group and ultimately rejected the proposals in favour of the reviewable sentence. What is most notable, however, is the rejection by the 1999 Green Paper of most of the experts' central recommendations and the decision to forge a different path. As noted earlier, this decision may be understood in light of the drive to find a solution to the immediate problem of the release of dangerous offenders from determinate prison sentences. The rejection of Fallon and Richardson's recommendations is also likely to have played a part in the strident opposition to the plans and the subsequent demise of the idea of a separate service for the DSPD group, discussed further below.

While the DSPD initiative was initially sparked off by a group of civil servants eager to continue work done under previous governments, interviewees also pointed to a "ministerial push" behind the plans. As can be seen from their comments in Parliament, the initial push came in particular from Home Secretary Jack Straw and Minister for Health Frank Dobson. Interviewees cited Dobson's conclusion that Care in the Community had "failed", Straw's desire to take on the psychiatric profession, and Tony

Blair's promise to be "tough on the causes of crime" as part of the political drive behind the DSPD proposals. Some interviewees also alluded to an interest taken by "Number 10" in the issue, which resided mostly in the need to protect the public:

> The [DSPD] Programme came about I think […] largely because of ministerial pressure, and from Number 10 it has to be said, 'oh something needs to be done with this difficult group, who we don't want running around, killing people', crudely (Civil Servant).

The DSPD problem was also seen as an opportunity for a new government to tackle a problem that provoked public fear in a way that previous administrations had failed to do. For ministers, here was "a seemingly intractable, intellectual problem", "a blank sheet" "vested interests that […] needed to be taken on, and […] a group of people who were at risk and who were a risk to others" (Politician). In other words, there was a gap, and Tony Blair's New Labour government had the opportunity to fill it. This gives weight to Rutherford's view that the proposals contained in the 1999 Green Paper "are more appropriately located within a proactive rather than a reactive scheme" (Rutherford 2006, p.79-80).

(b) High profile cases and the "real problem" of dangerous offenders

Given the findings of the Inquiry into his care and treatment, there are reasons to wonder why the Michael Stone case became such a potent "presentational" tool for the 1999 proposals (Rutherford 2006). As Jill Peay notes, Stone's problems were complex and it is unclear that he would have come within the DSPD criteria (Peay 2011b, p.178). At times his behaviour was attributable to personality disorder while at others he appeared to show signs of mental illness. In the five years preceding the murders, his main difficulties were with drug abuse rather than personality disorder. Delays in publishing the Inquiry's report are likely to have contributed to the continuing association between the Stone case and the DSPD proposals. The report was completed in November 2000 but was not published until September 2006, some 10 years after the crimes had been committed and 8 years following Stone's conviction.

The delay left significant time for inaccurate media reporting on the case to influence debates on the DSPD proposals. This was clearly true in case of the Home Affairs Committee, which reported in 2000 that the Stone case "highlight[ed] such issues as

why people are released from prison when they are known still to be dangerous, why the courts do not give discretionary life sentences in appropriate cases and why people who ask for medical help do not necessarily receive it" (Home Affairs Committee 2000a, para. 3). In the eyes of the Committee, the Stone case gave rise to the rhetorical question of whether it was "right that the State should be powerless to intervene in a case where someone has yet to commit a criminal offence and whom the medical profession consider to be untreatable, even if that person poses a very real danger to society" (Home Affairs Committee 2000a, para. 3).

Inaccurate media coverage was not confined to the Stone case. An article in *The Guardian* published in 1999 listed a number of "high profile cases of killers who had to be released while still deemed dangerous" (Travis 1999). The first mentioned was Michael Stone and it was falsely stated that he "told a nurse five days earlier of violent fantasies about killing and asked to be admitted to hospital, but he was deemed untreatable and refused a place" (Travis 1999). Another case cited was that of Darren Carr, who was employed as a live-in babysitter and went on to burn down the house of his employer, killing her and both her children. Carr was said to have been "released from a mental hospital after being diagnosed as untreatable in 1993" (Travis 1999). In contrast, the *Report of the Inquiry into the Treatment and Care of Darren Carr* (Richardson *et al.* 1997) noted that when Carr was released in October 1993 it was not because he was "untreatable" but because he had made progress in treatment and his detention was deemed to be no longer necessary. Agencies had previously taken action on several occasions where Carr's behaviour indicated a threat to others. While the clinical teams that assessed Carr could have decided that no mental illness was present and his psychopathic disorder was not treatable in hospital, they instead chose to admit him due to the risks he posed to himself and the public. Similarly to Stone, Carr would have been an unlikely candidate for the DSPD programme before the murders due to doubts surrounding his diagnosis and the absence of a record of serious offending.

Other cases cited in support of the DSPD proposals were of dubious relevance. In Parliament, Jack Straw referred to convicted sex offenders such as Robert Oliver who had been released from prison "with no conditions imposed on what they did or on where they lived" (HC Deb, 15 February 1999, col. 601). Minister Paul Boateng specified that "violent, predatory paedophiles" would be among the group targeted by the government's measures to tackle dangerous personality disordered offenders (HC

Deb, 25 February 1999, col. 394W). Given that the MHA 1983 excluded detention on grounds of "sexual deviancy" alone, however, many sexual offenders and paedophiles would have fallen outside the DSPD proposals.

Like the IPP sentence, the DSPD proposals may be better understood as a response to what was perceived by officials and ministers as the "perennial 'real problem'" of dangerous offenders being released from determinate sentences rather than to a small number of high profile cases (Annison 2015, p.33). Former Minister Paul Boateng offered anecdotal evidence of this problem to the Home Affairs Committee. Boateng described a visit to HMP Durham where prison officers told him about a man who was shortly to be released from a special unit. Prison officers described him as "highly dangerous" and "were absolutely convinced" he would reoffend. Although he had "been in prison for a long time" his "condition remained as it was and [he] presented a risk to the public" (Home Affairs Committee 2000b, Minutes of Evidence, 30 November 1999, para. 115).

One interviewee described the problem as follows:

> The proposition that Michael Stone was knocking on the door of a hospital only to be turned away perhaps is a bit apocryphal, but I've come across enough examples where the health service did not want an offender because they were too difficult or too dangerous and the custodial system was incapable of managing them properly or humanely because there was not an adequate component of health or psychiatric involvement to make sure that that person's needs were properly managed (Civil Servant).

Toby Seddon suggests that "discussions of actuarial tools, risk 'scores' and public protection might be taken to imply that the DSPD initiative has been largely an instrumental or technical phenomenon". He argues that the initiative had "powerful emotive dimensions too" (Seddon 2008, p.310). Seddon argues that, rather than being presented as evidence for ever-tightening social control exercised by a "paranoid" state, certain "risk-based strategies" may be better characterised "as pragmatic responses to legitimate anxieties" (Seddon 2008, p.313). These "anxieties" include public fears of dangerous offenders. This is reflected in the long history of efforts to address the "perennial 'real problem'" of high risk individuals serving determinate sentences (Annison 2015, p.33).

The proposals may therefore be understood in part as a rational response to individuals with a history of serious offending who are judged to pose a danger to the public and who could not be adequately managed by the prison and secure hospital systems. It is clear that the need to reassure the public also played an important part, however. One early policymaker conceded in interview that while the policy was not a reaction to it, the Stone case had contributed to an "atmosphere of needing to demonstrate that the government was doing something" about the perceived problem of recidivist mentally disordered offenders. This contributed a sense of urgency to plans that had in fact been in development for some time.

In this sense, the aim of the DSPD strategy was to enhance the objective and subjective security of the public. "Objective" security may be defined as a state of being protected from real or actual threats to safety. As a "subjective condition", on the other hand, "security" "suggests both the positive condition of feeling safe, and freedom from anxiety or apprehension" (Zedner 2003, p.155). Subjective states of security make no "reference to the objective reality to which the feeling may or may not pertain: they describe feelings alone" (Zedner 2003, p.155). Nikolas Rose (2010) highlights that public fears of the mentally ill and efforts to contain them appear to be out of proportion to the levels of risk they actually pose when compared to other groups, such as young men who consume alcohol (Rose 2010, p.87). He attributes this to the enduring fear of predatory "monsters" and the "fundamental division between 'we, the public' who can, in our imagination, conduct ourselves responsibly according to the norms of civility, and those others that threaten us" (Rose 2010, p.87).

Jonathan Wolff (2006), on the other hand, explains that the perception that some hazards are perceived to be "worse" than others of the same objective magnitude may be explained through the fact that they generate greater fear or "moral concern or outrage" (Wolff 2006, p.418). Wolff argues that "we blame people and organizations where we feel they have violated some moral norm; and an extreme form of blame is outrage" (Wolff 2006, p.419). Reoffending by individuals known to the criminal justice and mental health systems is apt to provoke blame and public outrage and calls for "something to be done" in response. The government appeared to be pressed to respond to these calls and put forward a set of radical proposals for preventive detention.

(c) An interdepartmental narrative

Rutherford notes that while the authorship of the 1999 Green Paper was "cross-departmental", the concerns of the Home Office and Department of Health in relation to the DSPD group "were rather different" (Rutherford 2006, p.56). For him, "the focus of the Department of Health was largely upon the quality of care and therapeutic interventions offered to the offenders, while that of the Home Office was primarily directed at public safety" (Rutherford 2006, p.56). In the early days, public protection seems to have been the main driver. In one statement by Jack Straw, treatment for the DSPD group has the appearance of an afterthought:

> We need a third approach, under which those who are suffering from severe personality disorders and who pose a grave risk to the public can be kept in securer conditions as long as they continue to pose that risk. There they may have treatment, if such treatment can be identified (HC Deb, 18 January 1999, col. 551W).

Closer to the publication of the plans, however, the tone changed and references to the health needs and social reintegration of the DSPD group were given increasing prominence. Thus, Jack Straw asserted that while the "key aim" of the proposals was "to protect the public", they were also intended to "[meet] the health needs of [DSPD] individuals" and give them "the best possible chance of becoming safe so as to be returned to the community, wherever that is possible" (HC Deb, 15 February 1999, col. 602).

Subsequent statements issued by the Home Office were careful to highlight the intended health benefits. Thus, in a Memorandum submitted to the Home Affairs Committee, the Home Office stressed that:

> [The] detention of dangerous severely personality-disordered people for the purpose of protecting the public is only one – albeit a very important one – of the Government's objectives in this area. Effecting a significant improvement in the way in which these people are treated, and the level of threat they present reduced, is a parallel priority. (Home Office 2000, para. 2)

Thus, there was no bright dividing line between the motivations of the ministers and civil servants involved.

Junior Minister Paul Boateng took the lead on promoting the proposals: first as Parliamentary Under-Secretary of State in the Department of Health in 1997 and subsequently as Minister of State at the Home Office in 1998 (see Boateng and Sharland 1999; Rutherford 2006). The plans also traversed the division between the health and criminal justice systems. In the words of the 1999 Green Paper, the "security, therapeutic and management needs [of the DSPD group] cut across services traditionally provided by criminal justice and health agencies [and neither] the prison service nor the health service [was] currently well placed to provide the full range of interventions they need" (Home Office and Department of Health 1999, p. 10).

Given the characteristics of the DSPD population as a distressed and dangerous group, for ministers and officials the solution could not be "just about locking them up and throwing away the key in the prison service and the prison punitive model, nor […] about some sort of therapeutic ideal" (Civil Servant). The resulting proposals were located somewhere between the two. The twin aims of the DSPD proposals – risk management and treatment provision – were described by one interviewee as an attempt to marry together the diverging objectives of the two ministries.

There was also a sense from policymakers from both the Home Office and Department of Health in interview that the institutional constraints and cultures of the health and criminal justice systems were part of the problem and there was a need to break out of them. On one hand, the prison service saw its role as "fundamentally about humane containment" (Civil Servant). Its "focus was about reoffending rather than necessarily […] intervening in the wider sense with prisoners to […] change their personality, enable them not just to not offend, but enable them to actually have a more productive and rewarding life, even inside their own heads" (Civil Servant). On the other hand, the health service was "very reluctant to get their fingers burnt by being saddled with responsibility for managing and treating a group of people that the clinicians felt that they could do nothing for, and very, very reluctant at having the label being pinned on them as being nothing other than jailors, kind of turn-keys" (Civil Servant). This may clearly be seen in the opposition to the plans discussed later.

Exposure to efforts to deal with similar problems in other countries also permitted policymakers to envisage a radical solution they saw as fitting with the British context. Members of the working group and ministers found visits to clinics in Holland,

Germany and the American State of Minnesota particularly illuminating. For these early policymakers, the American sexually violent predator laws were very much "focused on the issue of management and control [and] much too relaxed about keeping people incarcerated for long, long periods" (Politician). On the other hand, the Dutch *terbeschikkingstelling* (TBS) system was perceived to be better suited to the British context as it was "much more driven by therapy" (Politician). However, as a result, the Dutch were "much more willing to take risks [and] much more willing to spend a lot of money driving a therapeutic solution" than would be possible in the British context (Politician). Thus, the DSPD proposals "sought to chart a middle course" between the two models (Politician). At a time of economic prosperity, there was money available in government for the development of a new, ambitious service. In such a context, the idea of a separate system for offenders with personality disorders, free from the constraints of both the health and criminal justice systems, became feasible.

(d) Speaking the language of rights

Any plans to deal with the dangers posed by the DSPD group would have to comply with the recently promulgated Human Rights Act (HRA) 1998 (see Boateng and Sharland 1999; Home Office and Department of Health 1999). Human rights law therefore offered a language through which the compromise between health and security concerns could be expressed. In his evidence to the Select Committee on Health, Mike Boyle, Head of the Mental Health Unit of the Home Office, argued:

> If you look at the position as it applies at the moment where you have damaged, disordered individuals who are not receiving adequate services either from the Prison Service or from the NHS, who are distressed themselves, cause distress to their families and communities around them, and we are saying in effect there is no response to that, that seems to me to be an infringement not only of their human rights but of the human rights of the rest of society (Select Committee on Health 2000b, Minutes of Evidence,18 May 2000, para. 635).

The "middle course" was not only a compromise between the competing interests of the Home Office and Department of Health but was also presented as an effort to ensure public protection while meeting the rights of offenders to treatment and providing them with a route towards social reintegration. The perception that the DSPD group was not just dangerous but also needy formed the basis for an argument that the DSPD

proposals were a win-win situation. This was expressed in terms of a "balance between the human rights of individuals and the right of the public to be protected from these very dangerous people" (Boateng and Sharland 1999, p.7). The "deal" suggested by the government was stated by Paul Boateng as follows:

> Society has both a right and a need to protect itself from the actions of this small group of people who because of their disordered personality, pose an unacceptable level of risk of causing serious harm to others. But in return for taking action to protect itself by detaining these people, possibly indefinitely, society incurs an obligation to provide effective services to these people. Services designed to help them make the changes they need to so that they can return to the community safely. (Boateng and Sharland 1999, p.7)

In essence, the "balance" or bargain struck by the proposals meant that, in exchange for their detention to protect the public, dangerous offenders with personality disorder would be offered tailored treatments aimed both at alleviating their personal distress and reducing the risks they posed to the public so that they could eventually be released.

Gwen Robinson argues that current rehabilitative approaches with offenders are "a far cry from the rights-based model of offender rehabilitation, which many would wish to revive" (Robinson 2008, p.433). This appears to conflict with the central justification of the DSPD proposals that the provision of treatment they were a means of "balancing" the rights of offenders against those of the public. Viewed in this way, the justifications for the DSPD initiative have a great deal in common with the welfarist approaches to offenders that David Garland (2001) and Robinson (2008) argue have been displaced in "late modern" times.

The view taken of the DSPD offender by policymakers and practitioners as "damaged" and the "obligation" to provide interventions geared towards enhancing their wellbeing also suggests that welfarist motivations played an important part in the motivations of the policymakers behind the DSPD initiative. The emphasis was not only on treating the aspects of the person that led them to be a risk, as in the American model, but also on more holistic interventions to improve the offender's overall wellbeing. The proposals also indicate the survival of the rehabilitative ideal, as the proposals did not aim only to preventively detain dangerous individuals but also to rehabilitate them so that they could be reintegrated into society. This seems to contradict accounts of the decline of

penal welfarism (Garland 2001) and the turn towards a "new penology" concerned with managing rather than intervening with offenders (Feeley and Simon 1992).

Toby Seddon contends that the DSPD initiative was "hybrid" in nature as it represented the "coupling together of a novel focus on risk with a more archaic concern about dangerous subjects" (Seddon 2008, p.309). He also sees the DSPD programme as an example of New Labour's approach to penal policy, in which a "self-conscious 'toughness' has sat alongside a more conventionally progressive faith in the transformative potential of interventions with offenders" (Seddon 2008, p. 301). Seddon does not look much further into the source of this apparent contradiction, however. The "hybrid" appearance may be attributable both to the interdepartmental nature of the DSPD proposals and the compromise the proposals sought to strike between competing interests, expressed in terms of human rights and civil liberties.

The DSPD proposals, with their focus on offering treatment to a distressed group, appear at first glance to be more progressive and liberal than the IPP sentence, a measure also aimed at addressing the "real problem" of dangerous offenders released from determinate sentences (Annison 2015, p.33). According to Harry Annison, Home Secretary David Blunkett was suspicious of what he regarded as "liberal" civil servants (Annison 2015 p.53) and criminal justice Minister Lord Falconer was motivated by the desire to take "'aggressively populist anti-liberal stances' […] in the name of party image and electoral advantage" (Annison 2015 p.48, citing Anderson and Mann 1997, p.22). The more "progressive" aspects of the plans for DSPD may be attributable in part to the influence of "liberal" civil servants, who were given relatively free rein under Paul Boateng. The background of Paul Boateng as a civil rights lawyer is also likely to have had an influence on the presentation of the proposals and to have pushed them in the direction of a compromise between competing rights.

It was nonetheless evident from the 1999 Green Paper that where treatment was not found to reduce risk, public protection and indeterminate detention would prevail (Home Office and Department of Health 1999, p. 6). The need to appear "tough on crime" also played a role in the IPP sentence as Home Secretary David Blunkett sought to "balance 'liberal' or 'progressive' measures with 'tough' talk and action" to show that the newly elected government was capable of tackling crime issues just as well as the Conservatives (Annison 2015, p.46; see also p.47).

Dawn Moore and Kelly Hannah-Moffat (2005) argue that the progressive appearance of rehabilitative interventions forms a "liberal veil" that obscures the essential punitiveness of these practices. Similarly, references to "balancing" rights may serve to obscure the essentially coercive nature of preventive detention. The focus of the DSPD proposals on the offender's "right" to therapeutic intervention also serves to draw attention away from his right to liberty which is infringed in the pursuit of public protection. The analysis of the legal framework governing dangerous offenders with personality disorder presented in Chapters 5 and 6 of this thesis reveals a very similar mode of "balancing" competing rights. However, the clear priority given to the protection of the public over the rights of the offender calls into question the nature of the "balance" being struck. As will be seen later, the rights of individuals who have come in conflict with the law to liberty and freedom from disproportionate punishment are readily compromised in a model that prioritises the ill-defined "right" of a nebulous "public" to protection from dangerous offenders.

6. Controversy and the Demise of the Third Service

(a) Opposition to the plans

Opposition to the proposals in the 1999 Green Paper was vociferous and widespread. As Jill Peay remarked, "proposals which can unite in opposition MIND, the Law Society, Liberty and the Royal College of Psychiatrists suggest that the Government may need to reflect further" (Peay 1999, p. 23). Psychiatrists in particular were stridently opposed to the plans, and a flurry of critical articles appeared in medical journals such as the *British Medical Journal*, the *British Psychiatric Journal* and the *Lancet*. Psychiatrist Paul Mullen in an early commentary described the proposals as "glaringly wrong - and unethical" given the diagnostic difficulties surrounding personality disorder, uncertainties regarding treatment and the vagaries of risk prediction (Mullen 1999). He also voiced the profession's resistance to "the role of judges and jailers charged with maintaining public order" (Mullen 1999, p. 1146).

Psychiatrists were not alone in opposing the plans. Ronald Blackburn, a Professor of Clinical Psychology, was also critical of the DSPD concept. He asserted that "the idea of a clearly demarcated category of 'dangerous psychopaths' or 'severe personality

disorders' represents a disease entity approach which is at best a gross oversimplification and at worst a demonic stereotype" (Blackburn 2000, p. 2). He also criticised the DSPD construct as "inherently circular" as it was "likely that clinicians would judge the severity of a PD in terms of the serious antisocial behaviour supposedly resulting from it" (Blackburn 2000, p.8).

Concerns were particularly strongly expressed regarding the proposals for preventive detention in the absence of a criminal conviction. The Royal College of Psychiatrists, in its Memorandum to the Home Affairs Committee, was critical of what it saw as an attempt to use mental health legislation "to get around any absence of preventative detention in English Law" (Royal College of Psychiatrists 2000). The College further argued that it was not the role of the psychiatrist "to extend the sentence of those who have committed a crime or to impose one on those who have not" (Royal College of Psychiatrists 2000). In its view, "this would have disturbing echoes of the abuse of psychiatry in other countries that the College has fought so hard against in the past". Furthermore, it branded the government's "assumption that [the] proposals [could] be made compatible with the European Convention on Human Rights" as "naïve" (Royal College of Psychiatrists 2000).

There was also considerable opposition to the plans on legal grounds. Nigel Eastman (1999) voiced the suspicion that the proposals were designed to circumvent the prohibition on the preventive detention of persons not convicted of any offence in Article 5 of the ECHR by expanding the use of detention on the grounds of unsound mind. The Law Society also noted that "although the consultation paper states that the Government's proposals are not in breach of the ECHR, this is far from clear" (Law Society 2000). The Society was critical of the DSPD construct itself, asserting that "if people are to be deprived of their liberty, whether temporarily or indefinitely, because they are deemed to be in a particular category, that category must be clearly defined in the statute" (Law Society 2000). It further expressed concerns that, in view of the paucity of effective treatments, it was "difficult to see how people diagnosed as having severe personality disorder, who have also been deemed to pose a risk of dangerous behaviour, will ever be able to show they no longer pose a threat to public safety, particularly as they will be unable to rely on any clinical intervention to bring about an improvement in their condition" (Law Society 2000). It will be argued in the chapters that follow that this criticism is still apt today.

The Home Affairs Committee conducted an inquiry to examine "the balance" struck by the proposals "between protecting the public and respecting the human rights of individuals" (Home Affairs Committee 2000a). It ultimately came down in favour of Option B, stating "on balance" that "a separate service" was "most likely to protect the public, meet the needs of the individuals concerned and satisfy the requirements of the European Convention on Human Rights" (Home Affairs Committee 2000a, Recommendation 15). The Select Committee on Health performed a similar review but came to a very different conclusion. Unable to support either Option A or Option B, it recommended instead "that research should be initiated on the treatment of anti-social personality disorder, that adequate facilities should be made available within the NHS for those suffering from a recognised disorder who are able to benefit from treatment, and that further thought should be given to the proposal of reviewable sentences to provide those who are deemed a danger to the public but who are genuinely not amenable to treatment in the NHS" (Select Committee on Health 2000a, Recommendation QQ).

The controversy and the length of time it took to push through reforms to the MHA 1983 made it seem unlikely that something as ambitious as a separate service for the DSPD group would ever make it off the drawing board. As will be outlined in the next chapter, the decision was delayed pending the outcome of a pilot DSPD treatment programme and the plans for a "third service" would never be revisited.

(b) Looking back

One early policymaker interviewed was wary of the idea of a pilot programme due to the fear that "nitty-gritty practical stuff on running pilots and trials and all of that was going to turn into a way of kicking the third service idea into the long grass" (Civil Servant). Another described the setting up of the pilots as putting the third service "on the back burner" (Politician). In addition to outside criticism, resistance to the third service was seen to come from the Treasury, which perceived it to be "all too expensive and all too uncertain" (Politician). Resistance may also have come from other quarters, as one interviewee asserted: "the third service notion was one which was uncomfortable for virtually everybody, certainly for the Prison Service because you'd be losing some of your prisons and some of your staff and same for the Health Service". Thus, the idea

was “uncomfortable and challenging for lots of entrenched interests for the sake of a fairly speculative, long-term benefit” (Civil Servant).

Those involved in the later stages of the DSPD programme were not in favour of revisiting Option B. When I spoke to them almost 15 years after its demise, the third service idea was, however, generally still seen by the early DSPD “evangelists” (Peay 2011a, p.238) as the best solution to the problems identified. One early policymaker expressed regret that it had never come to pass. The interviewee attributed this failure to the inability of the policy team “to be completely crystal clear about describing this group in a way that would resonate with politicians generally and with other opinion formers and with the public” (Civil Servant). Another agreed that the third service was still the best way of doing things, and that it still hadn’t been “given a sufficient enough try” (Politician). A third policymaker was perhaps more realistic, commenting in relation to the third service that “you could say, ‘well it was always rose tinted spectacles that would have said that you can develop the whole thing’” (Civil Servant).

One striking finding to emerge from the interviews was the awareness demonstrated by policymakers of the problems with the DSPD initiative and their willingness to pursue the scheme despite them. The phrase “dangerous people with severe personality disorder” was described by one interviewee as a “compromise” and “an idea to try to define something that maybe wasn’t susceptible to being defined in that way” (Civil Servant). Another early policymaker remarked on the risk of slippage presented by the acronym “DSPD”, which was liable to “become misused as being ‘dangerous severe personality disorder’, as if the word ‘dangerous’ was qualifying the personality disorder rather than being a separate word to describe the people. And that’s exactly what happened” (Civil Servant). Indeed, it is notable that despite the fact that policy documents, ministers and officials consistently referred to “dangerous people with severe personality disorder”, this was misquoted in several critical accounts as “dangerous severe personality disorder” (Mullen 1999, p.1146; Blackburn 2000, p.2; Moran 2002). Somewhere along the way, the phrase was adopted as the title of the “Dangerous and Severe Personality Disorder (DSPD) Programme” (DSPD Programme *et al.* 2006; 2008a; 2008b). As will be argued in the next chapter, the plans for the DSPD programme eventually escaped their creators.

One policymaker argued that the DSPD label had the undesired effect of reinforcing the notion among health professionals that the initiative "was a Home Office driven agenda sort of about security and about locking people up" (Civil Servant). The cross-departmental nature of the compromise at the centre of the DSPD proposals and the support expressed by policymakers on both sides in interview and in documentary sources indicates that concerns for wellbeing were genuine. However, as noted previously, statements by Ministers and the 1999 Green Paper did emphasise that the protection of the public was the "prime concern" of the plans for the DSPD group. Furthermore, the campaign to remove the treatability criterion from the MHA 1983 may have undermined efforts to present the plans as therapeutically-driven.

The plans to preventively detain dangerous individuals without trial may also have contributed to the perception that the plans were punitive in nature. David Garland characterises preventive detention and the imposition of lengthy prison sentences on certain categories of offender as a "punitive" strategy that denies the limits of the state to control crime. He asserts that "together with their expressive or reductionist objectives, these 'law and order' policies frequently involve a knowing and cynical manipulation of the symbols of state power and of the emotions of fear and insecurity which give these symbols their potency" (Garland 1996, p.460). Similarly, Andrew Rutherford highlights the "instrumental" and "expressive" claims of the "eliminative ideal" which "strives to solve present and emerging problems by getting rid of troublesome and disagreeable people with methods that are lawful and widely supported" (Rutherford 1997, p.117).

It is questionable whether preventive detention in the DSPD proposals may be characterised as "expressive" of punitive sentiments, however. The "third service" was conceived as a means of detaining those who posed a danger to the public in a non-punitive therapeutic environment. Indeed, one interviewee involved in the plans viewed the links made by the media to the Michael Stone case as very damaging, as they "reinforced all the negative perceptions amongst psychiatric clinicians, that this was just a Home Office punitive agenda" (Civil Servant). Others were adamant that the DSPD proposals were not just "about locking people up" (Politician) but about finding a balance between public protection and meeting the needs of a neglected group of offenders. Notably, the policymakers involved with the DSPD proposals mentioned in interview that they were not in favour of the IPP sentence. In their opinion, the sentence

was too far skewed in the direction of punitiveness and did not strike the right "balance" between the rights of offenders and those of the public.

The centrality of finding effective treatment and management techniques to the compromise underlying the DSPD proposals also contradicts accounts that saw the initiative as "an ill-conceived attempt to hide the imposition of preventive detention and indefinite sentences behind the veneer of respectability provided by a mental health context" (Mullen 2007, s.3). These analyses are missing a closer look at the origins of the proposals and the programme that would have revealed a concern with enhancing offender welfare and providing a route to release shared by officials and ministers in the Department of Health and the Home Office.

The centrality of treatment to the compromise struck between the interests of the Home Office and Department of Health and between the rights of offenders and the public also casts doubt on claims that the subsequent DSPD programme was engaged in the mere "warehousing" of troublesome individuals (Tyrer *et al.* 2010, p.97) or that treatment was deployed merely to circumvent the requirements of the ECHR (Eastman 1999a; Blackburn 2000). This proposition will be examined further in the next chapter.

7. Conclusion

The proposals outlined in the 1999 Green Paper, and particularly the idea of creating a separate service, were an attempt to break with a history of failures and institutional biases and to put forward a radical solution to a problem which had become very high-profile. In addition to a drive to enhance public safety, a considerable part of the motivation behind the proposals was to improve provision for a difficult and neglected group. In the compromise formulated by the DSPD proposals, the conclusion that treatment could also be used to enhance public protection allowed a balance to be struck between the diverging goals of the Department of Health and the Home Office and between the competing interests of the public and dangerous individuals. However, in the rush to mark a new departure, insufficient attention was paid to the accumulated knowledge on the treatment and management of this group. The DSPD programme itself, discussed in the next chapter, illustrates the detrimental effects of arguably misplaced optimism and unrealistic expectations on the implementation of the policy.

As shall become clear in later chapters, therapeutic optimism has been scaled down and expectations have narrowed under the Offender Personality Disorder Pathway. However, the emphasis on monitoring risk has increased. Coupled with a greater reliance on indeterminate sentences, the ability to monitor risk without adequate means of reducing it indicates increasingly lengthy prison stays for those in the personality disordered group and grounds to fear increasing punishment. There are also grounds for questioning whether current rehabilitative interventions can deliver on the promise of reducing risk of reoffending and allowing offenders to be re-integrated into society. This casts doubt on the ability of the compromise underlying the DSPD proposals to strike an adequate balance between competing rights. The clear priority given to the protection of the public also indicates that the liberal and progressive appearance of the proposals conceals a more coercive reality. This argument will be developed further in the second half of this thesis, which will focus on the legal and normative issues arising from the treatment, management and detention of the DSPD group in the criminal justice and health systems.

Chapter 3: The Pilot DSPD Programme

1. Introduction

The previous chapter considered the origins of the policy that led to the establishment of the pilot Dangerous and Severe Personality Disorder (DSPD) programme. This chapter turns to consider the whether the DSPD initiative lived up to the lofty expectations of its originators and the allied question of whether it could have been expected to do so. Like the 1999 proposals, the DSPD programme was predicated on the notion that personality disorder and dangerousness were linked and therefore treatments for personality disorder could be expected to reduce recidivism risk and allow offenders to progress towards release. The programme also sought to improve mental health outcomes for a neglected group of offenders and improve their management in institutional settings.

Early assessments of the DSPD programme's ability to treat the prisoners and patients in its care were disappointing. Inmates received a surprisingly low number of treatment hours and their movement through the system was slow. These findings prompted psychiatrist Peter Tyrer and others to assert controversially that the DSPD programme was engaged in mere "warehousing" and was an attempt to hold back prisoners and patients the authorities were too afraid to release (Tyrer *et al.* 2010, p.97). Here it will be argued, however, that the DSPD programme was not a cynical exercise in containment because treatment was central to the compromise upon which it was based. It emerges from the analysis presented here, however, that in attempting to forge a new path, the creators of the DSPD programme did not take full account of past experiences and the limits of the evidence base for treating personality disordered offenders. As a result, the initiative failed in part to live up to the high expectations set for it in its early years. Nevertheless, the programme did achieve some successes in improving the management of a difficult group of offenders, developing new treatment programmes and building knowledge of the characteristics of the DSPD group.

2. The Pilot DSPD Programme

(a) Reforming mental health law

The proposals in the 1999 Green Paper were followed by White Paper entitled *Reforming the Mental Health Act* (Department of Health 2000a; 2000b). Part II of the White Paper dealt with "high risk patients", including those in the DSPD group. A rather curt summary of the 290 responses to the 1999 Green Paper was presented, downplaying civil liberties concerns in relation to the unconvicted as founded on "misplaced fears about the nature of the proposals and their scope" (Department of Health 2000b, para. 2.6). While noting that the majority of respondents (with reservations) and the Home Affairs Committee preferred the proposals for a "third service" for the DSPD group, any decision between policy options was to be delayed pending the outcome of a pilot assessment and treatment programme for the DSPD group. In the meantime, the government proposed to "bring forward those legislative changes that will be required whether Option A or Option B is adopted" (Department of Health 2000b, para. 2.12). To this end, the White Paper outlined plans to replace the various categories of mental disorder with a single definition and to "move away from the narrow concept of 'treatability'" in the MHA 1983 (Department of Health 2000b, para. 3.2).

Members of both the Fallon Inquiry and Richardson Committee disapproved of direction taken by the government on mental health law. Peter Fallon QC was critical of what he perceived to be an overly optimistic presentation of current "good practice" in relation to the treatment of the DSPD group and urged the government to consider his Inquiry's reviewable sentence proposal (Select Committee on Health 2000b, Appendix 28). Jill Peay, a member of the Richardson Committee, was critical of an earlier Green Paper, entitled *Reform of the Mental Health Act 1983* (Department of Health 1999b), published at the same time as the DSPD proposals. She described the Green Paper as "taking parts of the skeleton of Richardson, but abandoning its ethical heart […] and its principled musculature" (Peay 2000, p. 8). The paper had cherry-picked from the Richardson Committee's proposals, adopting the broad definition of mental disorder but abandoning the central principles of capacity and non-discrimination. The framework proposed in the White Paper followed this approach and revolved around avoiding risk of harm to the patient and others. The result, according to the Richardson Committee, was "an unfortunate hybrid […] which could significantly extend the use of compulsory powers" (Select Committee on Health 2000b, Thursday 6 April 2000).

Michael Cavadino saw the "safety-plus" approach of the 2000 White Paper as a serious threat to patients' rights and civil liberties (Cavadino 2002, p. 175). In relation to the plans for the DSPD group, he commented that "the prospect for most patients caught up in the new legal framework looks less likely to be a wonderful cure effected by treatments developed in the shiny new facilities followed by rehabilitation and timely release, and more likely to be old-fashioned long-term warehousing because no one knows how to treat them, but we are too scared to let them out" (Cavadino 2002, p. 188). This foreshadowed the later accusation levelled by Peter Tyrer and others involved in evaluating the pilot assessment process that the DSPD programme was engaged in mere "warehousing" and delaying the release of individuals the government was too afraid to release (Tyrer *et al.* 2010, p.97).

On 14 March 2000, John Heppell MP proposed a Private Members' Bill intended to create a DSPD order based on Option B in the 1999 Green Paper (Home Office and Department of Health 1999). The Bill did not advance past its first reading and was never raised again. A 2001 Progress Report on the DSPD programme confirmed that new legal powers would be created through the reform of the MHA 1983 and there would be "no separate powers or provisions for those who are DSPD" (Department of Health *et al.* 2001, p. 1).

A policymaker who was involved in developing the pilot programme was opposed to the idea of a DSPD order and saw it as a "Pandora's Box" (Civil Servant). Other interviewees pointed to a desire to operate within existing legal structures. This desire is also reflected in the history of the IPP sentence. According to Annison, in the "construction" of the IPP, a concern for compliance with the ECHR "intermingled with a more general sense of British fairness" "meshed with the legal official's natural inclination to view 'the best sort of change [as] the change which maintains continuity with what has gone before'" (Annison 2015, p.58, quoting Laws 2013, p. 93). The IPP sentence came to be modelled on the existing life sentence rather than on Fallon's reviewable sentence proposal. This move was to place considerable pressure on both the prison system and the Parole Board and contributed in part to the eventual downfall of the sentence, as considered in Chapter 5.

Political interest in the third service also began to wane, as ministers were reshuffled following the re-election of Labour in 2001 and the officials involved either moved on

or left the Civil Service. Debates on a new Mental Health Act continued in Parliament in the face of strident opposition from mental health professionals, lawyers and patients' rights groups. Finally, the MHA 2007 was passed, amending the MHA 1983 to broaden the definition of mental disorder to include "any disorder or disability of mind" and replacing the treatability criterion with the "aspirational" (Peay 2011a, p.238) "appropriate medical treatment" test. The pilot DSPD programme in hospitals began to operate several years before the changes were introduced, however, demonstrating that the existing legal structures were sufficiently flexible to accommodate a new service. This prompts the question of whether the removal of the treatability criterion was in fact necessary, discussed in Chapter 6.

(b) Setting up the pilots

The pilot scheme was intended to be an opportunity "to develop a 'what works' evidence-base" for the assessment, treatment and management of personality disorder and to assuage concerns regarding treatability, diagnosis and risk prediction raised by responses to the 1999 Green Paper (Department of Health 2000b, para. 6.23). The pilots were to be "rigorously and independently evaluated" and the results would inform future decisions about the structure of any new service and the introduction of new legal powers (Department of Health 2000b, para. 14). The White Paper acknowledged that the strongest study design would involve the "random allocation of subjects" and asserted that this would "be considered and chosen if possible (subject to ethical considerations)" (Department of Health 2000b, para. 6.53). However, as will be seen further below, a randomised controlled trial has not been undertaken and the effectiveness of the treatments delivered by the DSPD programme remains unclear.

The first high secure pilot for men opened in early 2001 in a refurbished prison wing at HMP Whitemoor known as D wing and later as the Fens Unit. A pilot DSPD hospital ward named Bicester Ward opened in Broadmoor in April 2003 with a small group of sexual offenders. The second prison unit for men, the Westgate Unit at HMP Frankland, was purpose-built and opened in March 2004. A purpose-built hospital unit, the Peaks Unit, opened at Rampton Hospital in March 2004 and in October 2005 Bicester ward at Broadmoor was replaced by the purpose-built Paddock Unit. The unit at HMP Whitemoor began as an assessment unit and by early 2005 both prison units were fully operational (Trebilcock and Weaver 2010b, p.22). The Primrose Unit for women at

HMP Low Newton opened in December 2006 and provided 12 beds within a prison wing also accommodating life sentenced prisoners (Department of Health 2011, p.4; Department of Health and NOMS 2011c, p.12). In June 2009, the Fens Unit at HMP Whitemoor had a capacity of 70 beds and the Westgate Unit at HMP Frankland had 86. However, only 61 and 76 respectively of the places were filled. In the same period, just 39 of the 48 places at the Broadmoor unit and 50 of the 70 places at the Rampton unit were occupied. The women's unit was at full capacity. In total, there were 238 patients and prisoners in DSPD services in June 2009, but 48 were described as "not actively in treatment" (Department of Health 2011, p.4).

It was intended that new specialist high secure services would fit into a "'whole service' approach" (Department of Health *et al*. 2001, p.1). Pilot programmes were also established in the community and three medium secure hospital units were commissioned. From the beginning, however, the bulk of spending went on the high end of the service. The reason for this was explained by a policymaker in the following terms:

> We would never have got the money from the Treasury to set up the whole end-to-end service as a single entity from the start from scratch. Never, ever, ever. What you had to do was to start focusing on the people who were of the greatest public concern, and they're the people in the high security services, and so you try doing something about them and then spread out from that (Civil Servant).

This top-down approach was later to pose problems for the progression of patients and prisoners through the hospital and prison systems.

Despite resistance to the third service idea on grounds of cost, there was clearly money for a pilot service. By June 2009, the total capital investment in the DSPD programme came to £128 million, including the three purpose-built high secure prison and hospital units, three medium secure hospital units and two NHS hostels. Annual spending was estimated at £40 million between 2003 and 2006 and reached £60 million in 2007 (HC Deb, 22 June 2009, col. 598-599W). The DSPD programme ran for over a decade and has been described as "one of the longest running and most expensive pilot programmes in UK history" (Rutherford 2010).

According to one civil servant in interview, the motivation of the Home Office in setting up the DSPD programme "was entirely public protection" while that of the Department of Health "was wellbeing". Like the DSPD proposals, the narrative that developed was a compromise born out of a "need to marry these two objectives together" (Civil Servant). Thus, the aim of the DSPD pilot programme was to create:

> [A] flexible service capable of responding to the fact that individuals in various combinations came to the system having committed some very serious offences. So there's a track record, if you like. This is not pretend. There's a genuine risk, having done it before there's a very genuine risk that they will repeat that exercise. But at the same time you had to treat them as human beings, in terms of providing support and the opportunity to come to terms with what they've done, understand themselves, because very often people didn't understand why they did it, and really to find coping mechanisms that reduced that risk (Civil Servant).

The civil servants involved in developing the programme were also concerned to allay public fears and dispel the myths that had grown up around DSPD, which included the notion that anyone with a diagnosis of personality disorder could be labelled as dangerous and swept up off the streets. Key to this process was determining the criteria for admission to the DSPD programme. The Planning and Delivery Guide for high secure services for men specified three criteria for entry onto the programme. First, it had to be demonstrated that the candidate was "more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover" (DSPD Programme *et al.* 2008a, p.8). Second, he or she must be diagnosed with a severe personality disorder as defined by one of three sets of diagnostic criteria. The first category required a score of 30 or above on Hare's Psychopathy Checklist Revised (PCL-R) (Hare 1991); the second a PCL-R score of between 25 and 29 and at least one personality disorder diagnosis other than ASPD in the DSM-IV (American Psychiatric Organisation 1994); and the third required two DSM-IV personality disorder diagnoses (DSPD Programme *et al.* 2008a, p.14-15). Finally, there had to be a link between the disorder and the risk of offending (DSPD Programme *et al.* 2008a, p.8).

The criteria stipulated by the Planning and Delivery Guide for women's high secure services also included a likelihood of serious harm and a link between the disorder and the risk of offending (DSPD Programme *et al.* 2006). The diagnostic criteria differed from those for men, however, and incorporated women with lower PCL-R scores but higher levels of comorbid personality disorders. The three categories were a PCL-R score of 25; a PCL-R score of between 18 and 24 and at least two DSM-IV personality disorder diagnoses other than ASPD; or a PCL-R score of 17 or less and three or more DSM-IV personality disorder diagnoses (DSPD Programme *et al.* 2006, p.12). The reasons for these differences were not given in the documents but may reflect the lower levels of psychopathy found in the female population (see Salekin *et al.* 1998).

The criteria for both men and women appeared to target a broader group than was originally envisaged by the DSPD proposals, which focused on dissocial or antisocial personality disorder and psychopathy (Home Office and Department of Health 1999). The Planning and Delivery Guides further advised that the diagnostic criteria "should be seen as guidelines rather than rigid boundaries for admission" (DSPD Programme *et al.* 2008a, p.15; 2006, p.12). As will be seen from the evaluative studies further below, the criteria for entry to the DSPD programme were applied flexibly by the units. In particular, the third diagnostic category of two or more DSM-IV personality disorders would allow individuals without a diagnosis of ASPD or a high psychopathy rating into the service. Subsequent evaluations of the DSPD programme found that a large proportion of those in the units were diagnosed with BPD, a disorder characterised by emotional instability and self-harming behaviour. This is an indication that the units were used to house prisoners that were difficult to manage in other parts of the prison system as well as those judged to pose a risk to the public.

(c) Therapeutic optimism and a limited evidence base

(i) The causal link

The "target outcomes" of the DSPD programme were "improved public protection", "new treatment services aimed at improving mental health outcomes and reducing risk", and a "better understanding of what works in the treatment and management of those who meet the DSPD criteria" (DSPD Programme *et al.* 2008a, p.6). The "underpinning philosophy" of the programme was "that public protection will be best served by addressing the mental health needs of a previously neglected group" (DSPD Programme

et al. 2008a, p.6). Thus, the "single most important factor" for admission for assessment was "the probable impact of the [personality] pathology upon the individual's offending behaviour" (DSPD Programme *et al.* 2006, p.12; 2008a, p.15).

At the time the pilot programme was established, however, it was not clear whether treatment for personality disorder could be expected to reduce an individual's risk of reoffending. Although there appears to be some association, "any attempt to infer a causal relationship between [personality disorder] and violence is fraught with difficulties" (Howard 2015, p.1). This is due to confounding factors such as "the overwhelming co-occurrence of multiple disorders, particularly in forensic psychiatric patients" (Howard 2015, p.1). Conor Duggan and Richard Howard concluded in a review that any causal link between violence and personality disorder is "weak" and that personality disorder, including ASPD, "probably accounts for only a very small proportion of the variance in violent behaviour" (Duggan and Howard 2009, p.29). This continues to be the case today (Howard 2015).

One civil servant involved in setting up the DSPD programme recognised that the idea of a "demonstrable link" was "a bit of a fudge in reality" because "how would you know, whether something was causative or co-occurring?" Like those who developed the DSPD proposals, civil servants involved in the DSPD programme were surprisingly aware of the problematic nature of the concepts with which they were dealing and the difficulties posed by the solutions that they themselves had a hand in developing. Despite this, they were also clearly willing to forge ahead. Part of the explanation may be found in how they viewed their role. According to one civil servant, "in a sense, if there's a policy imperative from ministers and they wish to see something happen, then the job of the civil service is to find a way of enabling the policy to be put into effect".

(ii) Psychological treatments

As noted in Chapter 2, while there was no consensus amongst mental health experts that personality disordered patients were intrinsically "untreatable", therapeutic pessimism seemed to hold sway in the late 1990s. As the Fallon Inquiry concluded, "there have always been dedicated enthusiasts convinced that they have the answer within their grasp, but there are also the sceptics, probably the majority, who point to the lack of credible evidence that treatment works" (Fallon 1999, para. 6.10.1). Despite the weakness of the evidence base, the pilots, together with generous research funding,

offered a response to the therapeutic nihilism of some psychiatrists. The narrative of the programme was "there's nothing we can do for [the DSPD group] now based on our present knowledge, and we need to just keep banging away until we find what that is" (Civil Servant). As expressed by another interviewee, "the whole point" "was not to give up on treatment" (Politician).

The use of psychological therapies with personality disordered patients has a relatively long history. The Butler Committee noted the 1957 Percy Commission's observation that "various methods of treatment in hospital had been provided for psychopaths, ranging from training under conditions of strict security to physical treatment, psychotherapy and group therapy" (Butler 1975, para. 5.28). By the time of the Butler Committee's investigation, two forms of intervention were available for those suffering from psychopathic disorder: placement in a therapeutic community, such as that at HMP Grendon, and psychological behavioural modification treatments, including social skills training, aversion therapy and operant conditioning (Butler 1975, para. 5.37). In 1986, the DHSS and Home Office commented in relation to psychopathic disorder that there were "indications of treatment potential but no valid generalisations about treatability or untreatability". It was also noted that "the most relevant treatment is likely to be social and psychological in character rather than drug-based, to include individual and group therapies, cognitive therapy, behaviour modification, milieu therapy and planned use of educational, occupational and social experiences and social skills training" (DHSS and Home Office 1986, para 14).

Around the time the pilot programme was introduced, evidence was also emerging for the effectiveness of some psychological interventions with personality disordered individuals. In randomised controlled trials, dialectical behavioural therapy (DBT) had been shown to be more effective than treatment as usual in reducing the severity and frequency of self-harming behaviour and improving overall functioning in women diagnosed with BPD (Linehan *et al.* 1991; 1993; Linehan 1993). There were also some indications that cognitive behavioural therapy (CBT) had positive effects for patients diagnosed with ASPD from a case-based study (Davidson and Tyrer 1996). Reported benefits included improved interpersonal relationships and decreased irritability. The findings were not robust, however, due to the small sample size, absence of a control group and short study period.

There was less evidence for effective treatments for high risk patients with complex problems such as those in the DSPD group. A review commissioned by the Home Office found a near-total lack of clinical literature on either "severe" or "dangerous" personality disorder (Warren *et al.* 2003). The review found some studies reporting successes in treating personality disordered offenders, but several were methodologically flawed and doubts were expressed about the applicability of their findings to high-security category prisoners. The authors concluded that the most promising intervention was patient participation in a therapeutic community and there was also some evidence to support the use of DBT with women with BPD (Warren *et al*. 2003). Nonetheless, using high-security categorisation as a proxy for "dangerousness", they concluded that overall there was "no evidence that "DSPD" can or cannot be treated" (Warren *et al.* 2003, p.120). The review therefore left room for the optimistic stance that a lack of robust evidence that the available treatments "worked" did not prove that "nothing worked". This therapeutic optimism also appeared to fuel hopes that the service could break with the "the weight of history and accumulated failures" of the prison and secure hospitals in dealing with the DSPD group (Fallon 1999, para. 7.12.4).

On a more cynical level, the pilots were also a response to a need for the government "to be seen to be doing something" about a problem of public concern (Civil Servant). As one civil servant commented in interview: "in government often what pilots do is provide a vehicle for putting difficult things in a box and saying 'yes, we're doing something about it but we'll need to wait to see what the results are'" (Civil Servant). They also helped to alleviate some of the pressure: "to some extent the imperatives, the immediacy around being seen to be doing something had gone, because you *were* doing something" (Civil Servant). This need "to be seen to be doing something" seems to have taken precedence over the need to work out the finer details. As another civil servant explained, "inevitably ministers are particularly concerned about public perception. And public perception, rightly or wrongly, emphasises concerns about danger presented by particular individuals". This indicates that providing the public with symbolic reassurance that "something" was being "done" in response to the fears provoked by dangerous offenders was just as important as acting to protect the public from those released from determinate sentences. As will be argued below, this allowed the policy to

go ahead despite acknowledged difficulties with the evidence base and some of the assumptions underlying the initiative.

3. Lessons from the Past

(a) Treating personality disordered patients in hospital

Susanne Dell and Graham Robertson's study *Sentenced to Hospital: Offenders in Broadmoor*, published in 1988, provides insights into the manner in which male patients detained under the legal category of psychopathic disorder in the old MHA 1959 were managed and treated in the old Special Hospitals. At the time of the study, such patients made up about a quarter of Broadmoor hospital's residential male population (Dell and Robertson 1988, p.63). It is striking that many of the issues encountered at Broadmoor also arose in the DSPD units. This prompts the question of whether the DSPD initiative, in seeking to break with institutional failures, failed to build on lessons from the past.

In terms of treatment, Dell and Robertson note that individual and group psychotherapy, social skills training and behaviour modification programmes were available to male patients detained on the grounds of psychopathic disorder. At the time of the study, only a small minority of patients were taking part in any therapy, however, and much of the care was "custodial" in nature (Dell and Robertson 1988, p.87). According to the authors, the patients had spent an average of 8 years in the hospital and for at least two-thirds of that time "the only treatment they received was that of 'being there'" (Dell and Robertson 1988, p.91). The patients "often expressed unhappiness at the lack of programmes directed towards their specific needs, feeling that they had come to Broadmoor on a false prospectus – one that promised them treatments that were not forthcoming" (Dell and Robertson 1988 p.124). In the view of practitioners at Broadmoor, life in a secure hospital setting was a form of therapy in itself, referred to as "milieu therapy", as patients were encouraged to learn acceptable behaviours through their interactions with staff and other patients (Dell and Robertson 1988, p.91). Many patients disagreed with this, however, and were disappointed with what they perceived to be insufficient levels of therapeutic input.

Maturation was considered a remedy for psychopathy at Broadmoor and was often cited by psychiatrists as a reason for discharging patients detained under the category of

psychopathic disorder (Dell and Robertson 1988, Chapter 8). There is some evidence that the passage of time may succeed where therapeutic intervention does not. Criminological research shows that antisocial behaviour peaks in adolescence and decreases markedly with age (Moffitt 1993). Furthermore, most antisocial and psychopathic personalities go into remission when patients reach their 30s and 40s (Martens 2000). The Fallon Inquiry also found that little active treatment was being undertaken at Ashworth and an inquiry into Rampton hospital in the 1980s noted a focus on containment rather than therapy (Fallon 1999, para. 1.19.1, citing Boynton and Department of Health and Social Security 1980). As one interviewee commented: "the whole ethos of high security hospitals in relation to personality disorder was not so much treating them but just kind of waiting them out and custodial" (Practitioner). As discussed later, the theme of "waiting" was to emerge strongly from evaluations of the DSPD programme (Tyrer *et al*. 2007; Burns *et al.* 2011).

Nevertheless, many patients at Broadmoor felt that they had gained some benefit from specific treatments. Half of those patients who had engaged in individual psychotherapy found it "very helpful" and a quarter found it "quite helpful" (Dell and Robertson 1988, p.87). Patients commented that they had developed a greater understanding of themselves and their problems through therapy and they were better able to communicate with others, build relationships and develop trust. The majority of patients also found behaviour modification and social skills programmes useful. Group therapy was less well-regarded, however, partly due to concerns amongst patients that they could not speak freely of their offences with others (Dell and Robertson 1988, p.87).

Dell and Robertson noted a small number of patients in the hospital had been transferred there from prison towards the end of determinate sentences for detention rather than treatment. These patients were "hostile, bitter and uncooperative" (Dell and Robertson 1988, p.67). Once admitted, however, if their offences were sufficiently serious, they were in effect "undischargeable" even though their disorders may not have been amenable to treatment (Dell and Robertson 1988, p.78). The Fallon Inquiry also highlighted that there had been pressure on Ashworth Hospital to take patients who were dangerous but who could no longer be detained in prison. The problem with this approach was that it could result in the hospital acquiring "a ward full of […] people for whom nothing positive could be done" (Fallon 1999, para. 1.38.2). A further difficulty was posed by patients transferred to Ashworth from prison who still had time to run on

their prison sentences. These individuals had little incentive to engage with rehabilitation programmes preparing them for release when they could be transferred back to prison to complete their sentences (Fallon 1999, para. 1.40.1). This inertia, in the eyes of the Inquiry, contributed to some of the problems at Ashworth. Fallon concluded that "the functions of hospitals and prisons as far as personality disordered offenders [were] concerned [were] dreadfully confused" and that secure hospitals were in effect "being used as surrogate prisons" because there was no other means of detaining this category of dangerous offenders indefinitely (Fallon 1999, para. 1.43.7).

The problem of "late transfers" continued into the DSPD programme and the amendments to the MHA 1983 were in fact aimed at facilitating the detention of those nearing the end of their sentences. The attack by Jack Straw on psychiatrists perceived to be "cynically hiding behind the 'treatability' clause in the Mental Health Act 1983" (Maden 2007, s.8) is a further indication that the experiences of Broadmoor, Ashworth and other secure hospitals left with disgruntled "untreatable" patients were not taken into account in developing the proposals for the DSPD programme.

(b) Personality disordered offenders in the prison system

According to John Milton and Gopi Krishnan (2010), a study published in 1998 showing high levels of personality disorder amongst male and female prisoners in England and Wales (Singleton *et al.* 1998, p. 10) gave rise to a feeling within government that greater provision had to be made for this group. Although some special units were in operation, the Fallon Inquiry found that the "vast majority of personality disordered prisoners" were "dealt with on general location, with no specific provision to meet their needs" (Fallon 1999, para. 1.35.6). The most disruptive prisoners were being "transferred from segregation unit to segregation unit, often every six weeks [where] they would receive […] little or nothing in the way of constructive activity or opportunity to address their behaviour" (Fallon 1999, para. 1.35.8).

Before the DSPD programme was introduced, the very dangerousness of some prisoners precluded them from participating in interventions aimed at reducing the risks they posed. The Butler Committee (1975) noted that some personality disordered offenders were excluded from pre-release home leave and employment schemes as they were thought to be too dangerous. This had the paradoxical result that the most dangerous offenders on determinate sentences were released without prior socialisation. A similar

trend was the exclusion of offenders with high psychopathy scores from treatment programmes in prison. Karen D'Silva and colleagues (2004) attributed this to studies that purported to show that treatment could actually enhance the risk of recidivism in such patients (e.g. Rice *et al.* 1992). This led to a "Catch 22 situation" in which prisoners were told they must complete certain programmes to be considered for parole but were then refused entry onto the required programmes due to their high PCL-R scores (D'Silva *et al.* 2004, p.163).

Disruptive prisoners also caused problems for the administration of the prison system. A Home Office working party, the Control Review Committee (CRC), was established in 1983 in the wake of major prison riots. The Committee advised the establishment of special units, positioned "midway between segregation and the ordinary wing, where prisoners who have difficulty with normal prison conditions can be helped to find ways of coping in smaller, more supportive situations and then guided back into the mainstream when they are ready" (Home Office 1984, para. 68). The first CRC unit opened at HMP Parkhurst in December 1985 and was followed in May 1987 by a unit at HMP Lincoln and in November 1988 by a unit at HMP Hull (Walmsley 1991, p.4). In the Parkhurst unit's first two years, almost half (48%) of the inmates were found to have a personality disorder or psychopathic traits, a further 13% were suffering from paranoia or psychotic or schizophrenic illness and 13% had both (Walmsley 1991, p.15). The bulk of these prisoners were serving long sentences, with 60% serving life sentences and between 20% and 25% serving sentences of 10 years or more. The majority had been convicted of homicide (40%) or violent offences (35%) (Walmsley 1991, p.14).

In February 1998, Close Supervision Centres (CSCs) came to replace the CRCs and had a similar purpose (Clare and Bottomley 2001, p.vii). The Intervention Centre at HMP Durham, known as I Wing, was intended to offer "psychiatric assessment and specialist input to the practical management of prisoners with personality disorders" and "to monitor, assess and review individual prisoners' cases so as to prepare them for a return to normal location, progress to an alternative CSC or transfer to a psychiatric hospital as appropriate" (Fallon 1999, paras.1.35.10-11). CSCs were small, each holding 10 prisoners or less at a time (Clare and Bottomley 2001, p.72). A Home Office evaluation of the CSC system conducted between 1998 and 2000 was largely unfavourable, finding low levels of constructive activity, compromised safety, problems with staff retention

and poor outcomes for prisoners in terms of progression, particularly at the HMP Woodhill units (Clare and Bottomley 2001). I Wing at HMP Durham fared better, as staff-prisoner relations were good, but there were problems with recruiting and retaining a psychologist to work in the unit (Clare and Bottomley 2001).

The CSC system has since evolved, with the Durham unit closing and new units opening at HMP Whitemoor and HMP Wakefield (HM Inspectorate of Prisons 2006, para. 1.7). There are also CSC-designated cells in segregation units in other high security prisons to which CSC prisoners may be transferred (HM Inspectorate of Prisons 2006, para. 1.11). An inspection by HM Inspectorate of Prisons in 2006 again found little meaningful activity was being provided for CSC prisoners in the most restrictive wings at HMP Woodhill and lockdown was common (HM Inspectorate of Prisons 2006, para 3.7-3.9). The regimes at HMP Whitemoor and HMP Wakefield were more positive. A consultant psychiatrist at the time of the 2006 inspection commented that two thirds of CSC prisoners had mental health problems that would benefit from psychological or pharmacological treatments. The diagnoses of CSC prisoners were similar to those on the DSPD programme: "anti-social, borderline and paranoid personality disorder, psychopathy, post-traumatic stress disorder, depression and anxiety" (HM Inspectorate of Prisons 2006, para. 3.77).

In lower security conditions, therapeutic communities (TCs) have also been developed to treat personality disordered offenders in prisons and secure hospitals. This model involves "the creation of an environment in which complex interpersonal and community processes become central therapeutic factors and are subject to detailed analysis, as well as being considered as a primary medium of treatment" (Warren *et al.* 2003, p.14). TCs are characterised by democratic decision-making and mutual respect between staff and patients or prisoners. Participants in the community are encouraged to take responsibility for their own behaviour and to contribute to the treatment of others (Warren *et al.* 2003, p.14-15). Research on TCs has not been able to establish conclusively whether they are effective in reducing reoffending or improving mental health outcomes but there have been some encouraging results (Warren *et al.* 2003).

Admission to TCs such as that at HMP Grendon is on a voluntary basis and the admission processes are selective as not all prisoners are suitable for the democratic therapeutic environment. For example, prisoners must be drug free, those with mental

illnesses or disabilities are excluded, and the prison will take only Category B or C prisoners (HM Chief Inspector of Prisons 2014). These restrictions do not apply to the DSPD units in Category A prisons but DSPD patients and prisoners may progress to a TC if they fulfil the entry criteria. For practitioners in the prison DSPD units, a move to a TC is not necessarily the next step on from a DSPD unit but it can be part of a prisoner's route towards release. According to prison practitioners in interview, referrals to the DSPD programme came largely from CSCs, segregation units and normal prison wings. Thus, the DSPD units came to occupy a space between the restrictive segregation units and CSCs that took the most difficult prisoners and the more liberal and selective TCs.

The experience of the CSCs, much smaller than the DSPD units, illustrate the problems associated with holding disruptive prisoners together and the strains that this can put on staff. It also illustrates the difficulties with maintaining a constructive therapeutic regime for the most difficult and disruptive prisoners. These problems continued into the DSPD units, where the levels of therapy were far below those expected of an intensive therapeutic programme. Nevertheless, as will be considered later, the DSPD units did make progress in the successful management of a difficult group of prisoners, and rates of violent disorder were lower than expected given the characteristics of the population.

4. Evaluating the "DSPD Experiment" in High Secure Services for Men

(a) The pilot assessment programme

An external evaluation of the DSPD assessment programme for men at HMP Whitemoor was commissioned by the Home Office and Department of Health and carried out between 2001 and 2005 by a group from Imperial College, Arnold Lodge and the University of Oxford (IMPALOX) (Tyrer *et al.* 2007; 2009). The IMPALOX study found that the assessment period was unnecessarily long, largely due to staffing problems, and levels of therapeutic activity on the wing were low. Therapy groups were initially run by psychologists but these were stopped to allow staff to spend more time on prisoner assessments and report writing. Prison officers created new groups based on discussion and skills teaching to fill the gap left by therapists. In the qualitative

component of the study, psychologists on the unit reported that they felt overburdened and under-supported while prison officers often felt the work they did was underappreciated. On the other hand, several prison officers, many of whom had volunteered for or had been approached by the unit, were pleased to have the opportunity to interact with prisoners in a more civil and progressive manner (Tyrer *et al.* 2007, p.48). The units tapped into a supply of therapeutically-minded officers who felt that this was "the future of the prison service" (Tyrer *et al.* 2007, p.48).

Prisoners were generally frustrated with low levels of therapeutic activity, delays in completing the assessment and beginning treatment, and the failure to provide the assessment reports they had been promised. However, like in Dell and Robertson's (1988) study, just over half of the prisoners interviewed reported gaining benefits from the assessment programme (Tyrer *et al.* 2007). These included greater insight into their personalities and offending behaviours and new ways of thinking they believed would help them to move forward. None of the prisoners had previously been offered such an opportunity, although some reported having participated in the Sex Offenders Treatment Programme (SOTP) (Tyrer *et al.* 2007). This reflects the paucity of treatment provision for prisoners with personality disorders prior to the establishment of the DSPD programme. However, the IMPALOX study also indicates that prisoners had high expectations of treatment and that these were frustrated by relatively low levels of therapeutic input.

Leon McRae's (2013; 2015) research on prisoners who had sought transfer to a specialist personality disorder ward in a medium secure hospital highlights that the motivation for many was the hope that engaging in the treatment programme would increase their prospects of early release. This motivation may also explain some of the frustration of the IMPALOX sample. The programme began with volunteers, and prisoners' motives for agreeing to referral noted by the IMPALOX team "included aspirations: to 'explain' or 'excuse' violent/sex offending by exploring 'causes'; to qualify for treatment; to move towards discharge from prison; [and] to satisfy parole and sentence management boards of reduced risk and willingness to work with authorities" (Tyrer 2007, p.139). On the other hand, "in the many cases where prisoners did not expect to gain freedom" the main motivation was "to improve their quality of life in prison" as many had spent time in segregation units due to their disruptive behaviour (Tyrer 2007, p.139).

For the first two years, the assessment programme at HMP Whitemoor received only volunteers, but after this period it also received prisoners admitted for assessment under a degree of coercion. According to the IMPALOX study, "later assessees were more likely to have fixed term sentences or be approaching tariff dates, and showed more ambivalence toward the assessment, questioning whether it was in their best interests" (Tyrer *et al.* 2007, p.51) Some of the later recruits said they had been "coerced into 'volunteering'", either because the Parole Board demanded they complete assessment before it would consider downgrading their security categorisation or because they were threatened with losing their enhanced status on the Incentives and Earned Privileges scheme (Tyrer *et al.* 2007, p.52). Perhaps as a result, these prisoners were more recalcitrant than the "treatment-seeking" early volunteers (Tyrer *et al.* 2007, p.51).

In an article reporting on a randomised controlled trial of the assessment programme (Tyrer *et al.* 2009), the IMPALOX researchers noted that the assessment programme was associated with better quality of life in terms of social relationships. However, there was an increase in aggression and worse social functioning in those with less severe personality disorders. The authors attributed these findings to the "frustration and unfulfilled expectations" of the prisoners found by the qualitative component of the research (Tyrer *et al.* 2009, p.132). A linked study of the costs of the DSPD assessment programme concluded that over six months, the DSPD group cost an average of £3,500 more than prisoners with similar characteristics in high secure control prisons and there was "a consistent trend for the DSPD assessment group to have worse outcomes than controls" (Barrett *et al.* 2009, p. 127).

In view of the high costs of the programme and lack of evidence of for its effectiveness, the IMPALOX researchers concluded that their "findings, together with concerns about treatability, raise[d] more fundamental concerns about whether medical management of people with these problems is a justifiable use of resources and ethically appropriate" (Tyrer *et al.* 2009, p. 144). In their view, "the portents for the success of this and similar programmes [were] not particularly good" (Tyrer *et al.* 2009, p. 144). The authors suggested that "concentrating the resources on those who are clearly motivated and determined to overcome their propensity to re-offend may be one way forward, but it is clear that this would only include a minority of those currently in the programme" (Tyrer *et al.* 2009, p. 98).

Members of the IMPALOX team and others published a further controversial article in 2010 entitled "The Successes and Failures of the DSPD Experiment" (Tyrer *et al.* 2010). The "successes" included large-scale investment in services for a much-neglected group of prisoners who would benefit from greater help and support in prison and hospital, whether or not the treatment programmes designed for them were proven to be effective in reducing recidivism (Tyrer *et al.* 2010). More generally, the authors noted that the interest in personality disorder generated by the DSPD programme had driven the development of countrywide personality disorder services and research into the treatment and management of the condition that could be expected to benefit patients beyond those in the DSPD category (Tyrer *et al.* 2010, p. 96).

The programme's failures appeared to outweigh its successes, however. The authors noted that each DSPD unit was administering "substantially different treatments […] with no apparent consistency or methodology being applied" (Tyrer *et al.* 2010, p. 97). They also expressed the concern that in the event of conflict it was likely that public protection would triumph over treatment (Tyrer *et al.* 2010, p. 97). Noting that less than 10% of the time patients and prisoners spent in assessment and treatment could be "regarded as direct therapeutic activity", the authors concluded that the government was engaged in the "warehousing" of offenders in a programme that would allow them to "be 'parked' for long periods thereby preventing them from being released from custody and re-offending in society" (Tyrer *et al.* 2010, p. 97).

A clear conflict emerged between the IMPALOX group and those working in the DSPD programme on what could be accepted as evidence of the "success" or "failure" of the programme. Malcolm Ramsay, one of the commissioners of the IMPALOX study at the Home Office, wrote an article in collaboration with two practitioners in the HMP Whitemoor DSPD unit, Jacqui Saradjian and Naomi Murphy, and head of research at the HMP Frankland unit, Mark Freestone, responding to the criticisms made of the DSPD programme by the IMPALOX group (Ramsay *et al.* 2009). The authors argued that the conclusion that the "portents" of the DSPD programme were not good (Tyrer *et al* 2009, p.144) appeared to be at odds with the full report of the IMPALOX study which found that some prisoners reported having benefitted from the assessment process (Ramsay *et al.* 2009; see Tyrer *et al.* 2007).

Kevin Howells and colleagues (2011) affiliated with the University of Nottingham and the DSPD unit at Rampton hospital also wrote a response to Tyrer and colleagues' (2010) "Successes and Failures" article. The authors attributed the low levels of therapeutic input recorded to the premature commissioning of the evaluations. Some units did not reach full capacity until 2009 while the IMPALOX study began in 2001 and concluded in 2006 (Tyrer *et al.* 2007). Much of the work of the units in the early stages was with men who had difficulty relating to others and who were "initially largely 'unready' to undertake intensive therapeutic work" (Howells *et al.* 2011, p.132). The authors contended that "a scientific rather than a scientistic approach" was required for the future evaluation of the DSPD programme (Howells *et al.* 2011, p.132). The former "would involve systematically and organically building up knowledge about the population, their characteristics and needs, the service itself and the therapies offered and their outcomes". On the other hand, "the latter would jump prematurely and exclusively to methods wearing the badge of scientific respectability, such as the randomized controlled trial which, of course, certainly has an important, but not exclusive, role to play in the longer term" (Howells *et al.* 2011, p.132).

In interview, practitioners from the DSPD programme relied on anecdotal evidence of prisoner and patient progress to demonstrate the effectiveness of the treatments on offer. This contrasts with the prevailing trend for "evidence-based medicine" (see Greenhalgh *et al.* 2014) followed by the IMPALOX team and initially endorsed by the Department of Health (2000b). Practitioners often described the treatments delivered by the DSPD programme as "evidence-based". At first, this appeared to be a misleading term in view of the conclusions of systematic reviews of the evidence for treating those categorised as DSPD (Warren *et al.* 2003) and those diagnosed with ASPD (Gibbon *et al.* 2010; Khalifa, 2010). Upon further investigation, however, it emerged that the treatment programmes developed by the individual DSPD units drew on treatments that had been found to be effective with other populations. This included DBT, found to be effective for women with BPD, and CBT-based offending behaviour programmes, found to reduce reoffending amongst the general prison population. In light of this, Howells and colleagues commented that the assertion that "no treatment with a satisfactory evidence base could be recommended" (Tyrer *et al.* 2010, p.97) was "overstated" (Howells *et al.* 2011, p.131). The authors concluded that "while there are important issues relating to how offender programmes need to be modified for a personality disorder population it

remains the case that a substantial evidence base as to likely outcomes and principles of effective treatment does exist for the DSPD clinician" (Howells *et al.* 2011, p.131).

While the contention that the evaluations of the programme were commissioned too early seems to be valid, the lack of a control group in studies of treatment outcomes remains a problem for assessing the effectiveness of the DSPD programme. Prisoners in the IMPALOX study reported subjective benefits but the difficulties associated with conducting studies that meet the "gold standard" of the randomised controlled trial in forensic settings means that the evidence base for treatment effectiveness remains weak. Without a control group it is impossible to separate out the benefits derived from the various treatments deployed by the DSPD programme from the effects of maturation and placement in a specialist unit with higher staffing levels. The promise of treatment and individual attention may also have had a considerable placebo effect for a group that had been neglected by mental health practitioners. As will be discussed in the next chapter, the effectiveness of the successor of the DSPD programme, the OPDP, is also to be evaluated, but the short study period for the evaluation casts doubt on the extent to which convincing evidence of success can be produced.

(b) The pilot treatment programme

Two large-scale external evaluations of the DSPD pilot treatment programme for men in all four high secure units were commissioned by the Home Office and the Department of Health. An evaluation of the Primrose Programme for women at HMP Low Newton was completed in 2012 but has not been published. Efforts to contact the authors received no response. The *Inclusion for DSPD: Evaluating Assessment and Treatment* (IDEA) study examined the referral, assessment, treatment and management processes for patients and prisoners (Burns *et al.* 2011). The two-part *Multi-method Evaluation of the Management, Organisation and Staffing in High Security Treatment Services for People with Dangerous and Severe Personality Disorder* (MEMOS) study examined the organisation and staffing of the units, the legal status of DSPD patients and prisoners, and the impact of DSPD status on Parole Board and Mental Health Review Tribunal decision-making (Trebilcock and Weaver 2010a; 2010b; 2012a; 2012b; 2012c). The findings of these studies seem to show that the DSPD programme did not meet the high expectations set for it by policymakers as treatment hours were fewer and patient and prisoner stays longer than anticipated.

According to the IDEA study, DSPD patients and prisoners had many common characteristics. They were overwhelmingly white and UK-born, had long histories of mental disorder, custodial care and convictions for serious violent and sexual offences. Psychopathy ratings were high, with an average score of 28 on the PCL-R scale and 40% of participants scoring 30 and above (Burns *et al*. 2011, p.xi). However, 17.2% of patients and prisoners were admitted under the diagnostic category that did not require ASPD or a high PCL-R score (Burns *et al.* 2011, Table 3.8). The lowest recorded PCL-R scores were 13 in the prisoner group and 18.9 in the hospital patient group, well below the cut-off point for psychopathy of 26 for European samples (Burns *et al.* 2011, Table 3.14; p.46). Thus, there was evidence that the DSPD units were admitting a high-risk group of serious offenders but also that the criteria for entry were being applied flexibly. The IDEA researchers noted that a quarter of those on the DSPD programme did not meet the criteria and commented that this was "more than one might expect in such a controversial (and administratively defined) category" (Burns *et al*. 2011, p.235-236). The criterion least likely to be recorded by the units was that of a link between the personality disorder and offending, which was noted in 60% of cases (Burns *et al.* 2011, p.36). This may indicate that the units were in practice moving away from the idea that personality disorder was causally linked to offending behaviour, as discussed in the next chapter.

The IDEA study found little difference between the prison and hospital units in terms of treatment outcomes. There were weak, but statistically significant, reductions in Violence Risk Scale (VRS) scores in both prisons and hospitals. This suggested that treatment may have been beneficial in the short-term (Ministry of Justice 2011a, p.7). Due to the lack of a control group, however, it was not possible to say for certain whether these reductions were a result of treatment or other factors affecting the participants (Ministry of Justice 2011a, p.7). The management of inmates in prisons may have been more effective than in hospitals, with fewer violent incidents being reported, although the authors suggested that the hospital units may have had a lower threshold for recording incidents (Burns *et al.* 2011, p.73; p.177).

There are indications that the units achieved some successes in managing a difficult group. A Home Office study (Taylor 2003) found that there were fewer violent incidents in the pilot DSPD unit at HMP Whitemoor than anticipated. For the 55 men on the unit, 10 violent incidents were recorded over two years, far less than the 37

predicted. However, the methods of the study may be questioned. The predicted number of incidents was found by calculating the average number of adjudications per prisoner over their whole prison careers. These ranged in length from 1.3 to 24 years and no account was taken of changes that may have taken place prior to the prisoners' admission to the DSPD unit. Given the relevance of maturation effects for personality disordered offenders (Dell and Robertson 1988; Moffitt 1993; Martens 2000), this oversight may have skewed the data considerably. Nevertheless, the IDEA study also noted that "despite the dangerousness of the sample and the very negative and hostile emotions expressed, relatively few security incidents occurred" (Burns *et al.* 2011, p.xvii). The researchers attributed this to factors including "relational and procedural security, including the high staff ratio based in relatively small units" (Burns *et al.* 2011, p.xvii).

While frontline staff working in the DSPD units reported that patients and prisoners were less violent and aggressive than they expected, many of those interviewed by the MEMOS study were surprised at the high levels of self-harm. Furthermore, most staff, including those with previous experience of working with personality disordered patients, "admitted to being shocked at the extent of perceived neediness and continual demands of the DSPD population" (Trebilcock and Weaver 2010b, p.80). This may indicate that staff members were not sufficiently prepared to work with such a difficult group of patients and prisoners. According to MEMOS, "concerns about young and inexperienced staff were familiar themes amongst interviewees from the hospital DSPD units" (Trebilcock and Weaver 2010b, p.39).

The levels of self-harm may also reflect the number of DSPD patients and prisoners diagnosed with BPD. A study of 203 male patients and prisoners admitted to high secure DSPD services between 2000 and 2007 found that over half were diagnosed with BPD and 48.8% were diagnosed with both BPD and ASPD (Kirkpatrick *et al.* 2010 p.278; p.270). There were also high rates of psychopathy, with 43.2% scoring over 30 and 77.8% scoring 25 or greater on the PCL-R (Kirkpatrick *et al.* 2010 p.269-70). The authors explained that prisons and hospitals were "more likely to refer [to the DSPD programme] individuals who stand out in terms of their behaviour or who are difficult to manage" (Kirkpatrick *et al.* 2010, p.278). This includes individuals with high PCL-R scores and those "characterised by high levels of emotional instability or repeated incidents of self-harm indicative of BPD" (Kirkpatrick *et al.* 2010, p.278). Patients at

Rampton hospital most commonly self-harmed to regulate or reduce negative emotions, to express aggression in a restrictive environment, and to influence others, for instance to gain attention or care (Gallagher and Sheldon 2010). This reflects the levels of personal distress of the DSPD patient group and also the traits of manipulativeness and aggression associated with antisocial personality disorders.

The most surprising finding noted by the IDEA study was that formal therapy took up an average of less than two hours per week (Burns *et al.* 2011, p.237). This compared to 9 hours of structured activities, such as work, education and leisure, in both prison and hospital units and 2.7 hours of "milieu therapy" in the hospital units (Burns *et al.* 2011, p.xiv). As may be expected given these figures, DSPD patients and prisoners interviewed by the IDEA team reported boredom and frustration with "waiting" for treatment and this was the greatest source of dissatisfaction for both samples (Burns *et al.* 2011, p. 205-206). This finding prompts a concern that Peter Tyrer and colleagues' predictions of "warehousing" (Tyrer *et al.* 2010, p.97) may have been made out (O'Loughlin 2014). A significant number of patients and prisoners, particularly in the hospital units, were unmotivated to engage in therapy or were actively resisting. This was seen by those who did engage as having a negative influence on the atmosphere of the units and on their own motivation (Burns *et al.* 2011, p.217-219). There were also concerns expressed by patients and prisoners regarding the mixing of predominantly sexual and predominantly violent offenders, particularly where therapy groups required participants to discuss their offending (Burns *et al.* 2011, p.220-221).

Howells and colleagues note, on the other hand, that one of the neglected "successes" of the DSPD units was the fact that they had managed to actually deliver therapy to a "challenging population" comprised of "individuals who have typically failed to engage meaningfully in treatment in previous non-DSPD settings or been denied treatment due to their so-called untreatability" (Howells *et al.* 2011, p.130). The findings are nevertheless surprising given the emphasis on therapy in policy documents and programme delivery guides and the intention for the programme to be intensive (see DSPD Programme *et al.* 2008a; 2006; Home Office and Department of Health 1999).

Movement through the DSPD programme also appeared to be slow. At the beginning of the MEMOS study in July 2006, the vast majority of those in the prison sample (82%) were serving indeterminate sentences, generally life sentences, with just three detained

under IPP sentences. The low numbers of IPP prisoners reflects the fact that the dangerous offender provisions of the CJA 2003 came into force in April 2005, a year before the MEMOS study began. The mean length of the tariff given to DSPD prisoners was 10.7 years and tariffs ranged widely from 2.5 to 30 years (Trebilcock and Weaver 2010a, p.30–1). Of those prisoners serving indeterminate sentences, 57% were admitted to the prison DSPD unit before the expiry of their tariff and the remaining 43% had passed their tariff (Trebilcock and Weaver 2010a, p.32). The remainder of the sample were serving determinate sentences (17%) (Trebilcock and Weaver 2010a, p.30–1). The mean determinate sentence length was 10.1 years and the range was from 5 to 16 years (Trebilcock and Weaver 2010a, p.31). The majority were in the early stages of their determinate sentence and 87% had not passed their "non-parole date": the date at which they could expect to be released at the end of their sentence if they had not been granted parole at the halfway point.

By December 2009, nine of the indeterminate sentenced prisoners and six determinate sentenced prisoners had left the DSPD prison units. Of the indeterminate sentenced group, two men had died and seven had been transferred to other Category A or B prisons for reasons including not meeting the DSPD criteria, assault on staff and refusal to engage in or co-operate with treatment. This indicates that even though the Planning and Delivery Guide explicitly stated that the consent of the prisoner was not required for transfer to a high secure DSPD unit (DSPD programme *et al.* 2008a, p.9), in practice uncooperative prisoners could be transferred out. In the determinate sentenced group, three prisoners had passed their non-parole date. One of these was released but subsequently recalled to prison, a second was transferred to a medium-secure hospital unit while a third remained in DSPD services having been resentenced for crimes committed while in the unit (Trebilcock and Weaver 2010a, p.33–4). Of the remaining three prisoners who had not finished their determinate sentences, two had been transferred to a Category A or B prison for unclear reasons, and one had been transferred to a secure hospital.

By contrast to the prison sample, 32% of patients in the high secure DSPD hospital units were serving indeterminate sentences while the majority (58%) had been given determinate sentences. Just 10% of the sample had received hospital orders, indicating that the vast majority had been transferred to hospital from prison (Trebilcock and Weaver 2010a, p.30–1). Hospital patients were more likely to have passed their tariff

expiry date or non-parole date than prisoners. By December 2009, 73% of indeterminate sentenced patients had passed their tariff expiration date and 85% of those given a determinate sentence had passed their non-parole date (Trebilcock and Weaver 2010a, p.40–1). These findings indicate that the hospital units were being used to detain high-risk offenders who had completed determinate prison sentences even before the changes introduced by the MHA 2007.

The MEMOS study demonstrates that very few prisoners in the DSPD units had progressed onwards from the programme and even fewer saw a reduction in their security categorisation. This casts doubt on the programme's ability to move offenders through the system. Nevertheless, the high security categorisation of DSPD prisoners should be borne in mind. In reviews of high security prisoners, the Parole Board can only recommend release or transfer to an open prison (Trebilcock and Weaver 2010a). Neither of these options was likely for the DSPD group, many of whom began in Category A or B. As a result, the success of the programme cannot be judged solely on the release rate. However, the MEMOS study also found that pathways out of the units were unclear and there were insufficient step-down services for patients and prisoners (Trebilcock and Weaver 2010a). This indicates that the focus on the top end of the service blocked prisoner and patient progress.

More positive findings were reported by clinical staff at the DSPD unit at HMP Whitemoor (Saradjian, Murphy and Casey 2010). According to the authors, five of the nine Category A prisoners in the first cohort of 18 men to finish treatment had been re-categorised and one man had been discharged into the community. It seems that the remainder were transferred to Category B prisons, but their security categorisation before coming to DSPD unit is unclear. Reductions in VRS scores for all but two men on the programme were also reported. However, due to the small sample size and the rather limited information provided by the article, it is difficult to fully assess the findings.

Similarly to IMPALOX, the MEMOS study noted problems with recruiting and retaining good quality and experienced staff to work in the DSPD units and recorded high levels of sick leave and burn-out. Over 26% of baseline staff at the units at HMP Whitemoor and Broadmoor hospital had left by the end of the 12 month study period. Rates of staff turnover were lower at Rampton, with 10.8% of staff leaving by the end

(Trebilcock and Weaver 2010b, p.34). Staff variously described working in the units as "interesting", "fascinating", "extremely complex", "challenging" and "frustrating" (Trebilcock and Weaver 2010b, p.79). While acknowledging that working in the DSPD unit was a "tough job", some staff asserted they had worked in more stressful environments (Trebilcock and Weaver 2010b, p.79). Others "revealed a range of negative experiences from being emotionally drained and infuriated through to occasional terror" (Trebilcock and Weaver 2010b, p.79). Each unit had "experienced a small number of serious incidents, including a patient being taken hostage, rooms not being locked at night, inappropriate staff-patient/prisoner relationships, near riots, and the death of a prisoner" (Trebilcock and Weaver 2010b, p.79). However, staff generally identified that it was the "accumulation of minor stresses" that led a feeling of being "worn down and emotionally drained" rather than rare but serious incidents (Trebilcock and Weaver 2010b, p.79-80).

The MEMOS study reported that patients spent slightly more time in therapy than the IDEA group, at less than 2.7 hours on average per week (Trebilcock and Weaver 2010b, p. 53). Keyworker sessions at the hospital units added another 69 minutes of "milieu therapy" (Trebilcock and Weaver 2010b, p.54). This calculation was based on scheduled sessions, however, and did not take into account cancellations. The study found that a relatively small proportion of staff time was taken up by face-to-face therapy sessions when compared to therapy-related "paperwork". At Frankland, face-to-face therapy accounted for 23.9% of staff time while 47.8% was occupied by preparation and de-briefing and 28.2% with collateral searches, scoring and report writing (Trebilcock and Weaver 2010b, p.53).

5. Explaining Unfulfilled Expectations

(a) An experiment

The findings of the early evaluations indicate that the DSPD programme had trouble living up to the lofty aspirations of policymakers. To some extent, as the DSPD programme was new it was difficult to foresee how it would turn out in practice. Thus, difficulties in getting the programme up and running are likely to have contributed to the IDEA study's conclusion that prisoners and patients were engaged in less than two

hours of formal therapy a week (Burns *et al.* 2011, p.237). As some civil servants commented in interview, nothing like the DSPD programme had been tried on such a scale before. On the other hand, several of the academics interviewed pointed to lessons from previous attempts to deal with this group that had not been learnt.

Although the DSPD programme seemed to have been influenced by the need to address the problems experienced at the Ashworth PDU, one academic commented that the programme itself was "surprisingly separate" from the recommendations of the Fallon Inquiry. For instance, the Fallon Inquiry had recommended the establishment of small specialist units in the prison and hospital systems housing no more than 50 prisoners, in contrast to the 70 places at HMP Whitemoor and 86 at HMP Frankland (Trebilcock and Weaver 2010b, p.22). The PDU had itself been an experiment, and the approach to the DSPD programme appeared to be similar: "it very much seemed to be: right, we're going to make a go of this. We're going to give you this money and we're going to find out kind of what happens almost again after the fact" (Academic). Furthermore, the decision to use the hospital units as places of preventive detention in many ways perpetuated the difficulties experienced at Ashworth, including patients resisting treatment, frustration with "waiting" and low levels of therapy and a paucity of constructive ways to occupy patients' time.

One civil servant involved with the pilot programme envisaged an intervention "in the pharmacological sense". In this view, patients and prisoners would receive 2 or 3 years of intensive treatment, after which they would be assessed and moved on to allow others to participate. This is reflected in the Planning and Delivery Guide for men, which specifies that "a clear case, in terms of treatment need, admission priorities and public protection, must be made where an individual is to remain on a unit longer than 3 years after commencement of treatment" (DSPD Programme *et al.* 2008a, p.17). The reality was much slower movement and longer stays. In the early days, practitioners forecast that prisoners would need 7 or 8 years to complete treatment. Although that time has since been reduced, at 5 years it remains substantial.

The comments of one civil servant appear to show that the fears of the early DSPD policymakers have been made out, and the enduring culture and traditions of the secure hospital and prison estates had a strong influence on what the DSPD programme was able to achieve:

> The prison service model and the health model to a degree colluded […] to put the programme in the space of therapeutic environment. So you spend as long as you need to before you get the benefit, as opposed to it's a relatively short period of active intervention, you get intensive support, intensive challenge, you review, you say yes it's worked or it hasn't worked.

Given the uncertainties regarding effective treatment and the experience of managing personality disordered offenders in secure hospitals and prisons in the past, this long-term approach does not appear surprising. The problem with the pilots, as identified by one civil servant, was that "given the nature of the sorts of patients who had been cared for in those units, looked after in those units, and the complexity and the lack of understanding [of their disorders], the fact that it was a developmental service, almost made it inevitable that you weren't going to see results for 10 or 20 years." Another interviewee expressed this more bluntly: "Nobody in their right mind could believe in a million years that personality disorder can be treated within a three year period. It goes against all the science" (Academic). A short-term, intense and effective programme may therefore have been an unrealistic expectation.

For some interviewees, the purpose of the evaluations was not necessarily to test what was working or what was needed, but rather came down to appearances. "If you're spending a lot of money on something […] you have to be seen to evaluate it" (Academic). This brings to mind the initial purpose of the pilot programme, which was expressed by one civil servant as "to be seen to be doing something" about the problem of dangerous offenders.

(b) Warehousing?

As noted previously, Tyrer and colleagues accused the DSPD programme of deliberately "warehousing" patients and prisoners in order to delay their release (Tyrer *et al.* 2010, p.97). This theme was explored with interviewees and several revealed conflicting views. One academic argued that a therapeutic "gloss" put on the programme by practitioners was a cover for the real intention of "holding people in the system because they weren't confident about releasing them". Nevertheless, the same interviewee also acknowledged that the prison officers and therapy staff "included some real enthusiasts […] who were actually really enthusiastic about treating prisoners as normal human beings, encouraging them to improve their ways, and treating them in a

much more respectable, respectful way, and were genuinely enthusiastic about the therapeutic potential of the programme" (Academic).

Another academic who initially believed the DSPD programme "was a slightly overinflated and overambitious but fundamentally therapeutic endeavour" later came to doubt the motivations of the Home Office. For this interviewee, the low levels of therapeutic input reinforced the suspicion that "the DSPD programme was actually a bit of a con trick, to find a way around European legislation to just keep locking up people for a very long time" (Academic). This reflects the concern expressed by Nigel Eastman (1999) that the DSPD proposals were a means of circumventing Article 5 of the ECHR. The same interviewee commented that while it seemed that "the practitioners were entirely genuine" and that no one had consciously proposed warehousing, as time went on it appeared that "locking people up" may have been more important than the programme's evaluators were led to believe.

A different view of the motivation of the Home Office was put forward by another interviewee, who commented that the programme "wasn't just a cynical exercise in containment" and "there was a real ethos of wanting to treat people" (Academic). However, problems emerged due to the nature of the patients being cared for, some of whom were resisting treatment. The hospital units in particular found themselves dealing with a difficult group of patients who had been transferred from prison to hospital towards the end of their sentences, essentially for preventive detention under the MHA 1983. The problems associated with "late transfers" were highlighted by Dell and Robertson in the late 1980s but yet one of the aims of the DSPD programme was to facilitate the continued detention of individuals nearing the end of their prison sentence. The Planning and Delivery Guides for both men and women's high secure services specified that transfer to a DSPD unit for assessment could take place without the candidate's consent (DSPD Programme *et al.* 2006; 2008a). However, the Guide for men's high secure services acknowledged the problem of disengagement with treatment and emphasised that "work on motivation and engagement [would] form a key part of the assessment and treatment process" (DSPD Programme *et al.* 2008a, p. 2). Nevertheless, the Guide also made clear that "considerations of need and public safety" rather than motivation to change would "remain primary in considering and prioritising admissions" (DSPD Programme *et al.* 2008a, p. 12). The Ministry of Justice later

acknowledged the problems posed by late transfers and now advises that transfer to hospital should take place as early in sentence as possible (Ministry of Justice and NOMS 2010). Late transfers remain a legal possibility, however, as discussed in Chapter 6.

As all DSPD hospital patients were detained under the MHA 1983, treating patients under compulsion was permissible in the hospital units. However, according to interviewees, this was not generally helpful in practice. Psychological treatments require patient engagement and motivation to change in order to be successful. Therefore motivational interventions became a large part of the work of both the prison and hospital DSPD units in their early years. Indeed, according to some interviewees, due to the small numbers of places on the DSPD units, motivation to engage with the programme became an informal criterion for admission.

In the prison units, on the other hand, compulsory treatment was not permissible. As noted previously, some prisoners were moved out of the prison units due to their refusal to engage with treatment. However, the IMPALOX study also notes that the Parole Board required some prisoners to be assessed for DSPD before being considered for downgrading to a lower security status, while others were threatened with the loss of enhanced status on the Incentives and Earned Privileges scheme if they did not comply (Tyrer *et al.* 2007, p. 52). Practitioners in the prison DSPD units mentioned in interview that once a prisoner had been referred to the DSPD unit, the programme would "remain on his sentence plan" and would not be removed until he accessed treatment. This meant that prisoners knew they would not have a chance of being released unless they complied with the programme. This implies that a level of coercion was present. As noted previously, coercion is likely to have a negative impact on the effectiveness of psychological treatments for personality disorder that require willing engagement and motivation to change on behalf of participants. Thus, the use of coercion may have undermined the key aims of reducing risk and reintegrating offenders into society. This argument is developed further in Chapter 7.

Given the operational problems noted by the evaluation studies, rather than an attempt at deliberate warehousing it may be more accurate to say that the practical difficulties of delivering treatment meant that the DSPD programme appeared to be engaged in mere containment despite its therapeutic intentions. The centrality of therapy to the DSPD

programme goes against Toby Seddon's analysis of the initiative as a means of excluding dangerous "monsters" (Seddon 2008, p.309). In the DSPD proposals and the DSPD programme, personality disorder and dangerousness were purposely conceived as potentially mutable qualities and the message was one of therapeutic optimism. As outlined in the previous chapter, the ultimate goal of the DSPD proposals was the social reintegration of the DSPD group rather than their perpetual exclusion. To some extent, therefore, the "monsters" of Seddon's account were conceived to be redeemable. The theme of redemption also underlies historical approaches towards the reform and rehabilitation of offenders and is explored further in Chapter 7.

6. The Legacy of the DSPD Programme

The legacy of the DSPD programme is mixed and its impact on the problems identified by the early policymakers is difficult to disentangle from other developments in law, culture and practice. As mentioned previously, the programme involved significant investment in a neglected population and generated greater interest in research on possible treatments for personality disorder. According to Conor Duggan (2011), broader developments in policy and "mainstream psychiatry", including the provision of specialist personality disorder training by the Department of Health and the formulation of NICE guidelines on BPD (NCCMH *et al.* 2009) and ASPD (NCCMH *et al.* 2010), would not have taken place without the DSPD initiative. Kevin Howells and colleagues (2011) argue that significant learning has emerged from the DSPD experiment in terms of treatment innovations, service delivery and the characteristics of the DSPD population (see for example Murphy and McVey 2010; Tennant and Howells 2010; Tew and Atkinson 2013). More research is needed, however, to confirm whether the DSPD programme met the aims of developing effective treatments for its client group and reducing the risks they posed so that they could be safely released. In particular, long term follow-up of the original DSPD cohort and randomised studies of current interventions are necessary to convince sceptics and form a robust evidence base for treatment.

What is clear, however, is that the prison DSPD units managed difficult prisoners effectively and at a much lower cost than in other parts of the prison system. According to the Impact Assessment for the OPDP (Department of Health 2011), if the DSPD

programme were to close, the use of CSCs would significantly increase. This would result in much higher costs as a place in a CSC costs £60,000 more per year than a place in a DSPD unit (Department of Health 2011, p.6). In addition, managing this group of prisoners without providing therapeutic interventions would result in increased levels of disruption, put additional pressure on the capacity of prison segregation units and lead to more prisoners being transferred from prison to prison (Department of Health 2011, p.6). It would also potentially lead to greater use of the Secretary of State's power to transfer prisoners to secure hospitals, where a bed costs around £290,000 per annum (Department of Health 2011, p.6). Thus it is clear that the introduction of the DSPD units brought significant benefits to the prison system in terms of the effective management of difficult and disruptive prisoners at a reduced cost.

The question of whether the DSPD programme resolved the problem of determinate sentenced prisoners being released while still dangerous is less straightforward to answer. Following the debate over the DSPD proposals and the introduction of the DSPD programme, the numbers of patients admitted to hospital on the grounds of psychopathic disorder rose from 40 in 1999 to 51 in 2002 when the first DSPD pilot opened, and peaked at 117 in 2007 (Ministry of Justice 2009a, Table 7). This represents an increase of 192%. By comparison, the numbers of patients detained on the grounds of mental illness in the same period increased by 23% (Ministry of Justice 2009a, Table 7). The numbers of prisoners transferred to hospital post-sentence under the MHA 1983 also increased by 82.6% (Ministry of Justice 2010b, Table 2). Statistics are only available in this form up to 2007 as the categories of psychopathic disorder and mental illness were abolished by the MHA 2007. These statistics may indicate increased willingness to admit patients to hospital on the grounds of psychopathic disorder following the introduction of the DSPD programme, even prior to the reforms introduced by the MHA 2007.

As noted previously, the reforms to the MHA 1983 introduced by the MHA 2007 made little difference to the operation of the DSPD programme. The Paddock Unit at Broadmoor began receiving patients as early as April 2003 and the majority of these had been transferred from prison (Trebilcock and Weaver 2010a, p.30–1). The treatment capacity of the DSPD units and the promotion of the idea that personality disorder should "no longer [be] a diagnosis of exclusion" (NIMHE 2003) by the government may have encouraged psychiatrists to admit greater numbers of personality disordered

individuals to hospital. The impact of the MHA 2007 is evaluated further in Chapters 5 and 6 of this thesis.

Another important legislative development was the introduction of the IPP sentence, which allowed for indeterminate sentences to be passed down on the grounds of future risk. Several interviewees were of the opinion that the IPP sentence had largely resolved the problem of the premature release of dangerous prisoners. Following the abolition of the IPP sentence by the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) 2012, the problem of dangerous offenders may be expected to resurface, potentially prompting greater reliance on transfers to hospital for personality disordered individuals. The impact of changes to the law of sentencing will be explored in greater detail in Chapters 5 of this thesis.

7. Conclusion

The aim of this chapter was to evaluate the extent to which the pilot DSPD programme lived up to the expectations set for it in its early years. While the programme appears to have had some success in improving the management of a difficult group, it encountered difficulties in delivering the intensive levels of therapy that were expected and many patients and prisoners were frustrated at the time spent "waiting" for treatment (Burns *et al.* 2011). A combination of unrealistic expectations, practical issues, and evaluations that were commissioned too early seem to have contributed to this finding. Following on from the analysis of the origins of the DSPD initiative in the previous chapter, it has been argued that the centrality of therapeutic intervention to the compromise embodied by the DSPD programme casts doubt on the assertion that it was engaged in mere "warehousing" (Tyrer *et al.* 2010, p.97). However, the slow progress of patients and prisoners through the system indicates that it may have operated as a means of holding them back as well as allowing them to progress towards release. Risk monitoring was an important function of the DSPD programme and this aim has taken on increasing importance in the programme's successor, discussed in the next chapter.

The high levels of BPD and self-harming behaviours amongst DSPD patients and prisoners indicate that the units were also used to house individuals who were difficult to manage on general location. These individuals may also have been more treatment-

seeking than more purely psychopathic or antisocial patients (Tyrer *et al.* 2007). In the proposals for the Offender Personality Disorder Pathway, the subject of the next chapter, expectations for treatment have become narrower and a greater emphasis is placed on risk assessment and monitoring. There is also evidence of a move towards reserving high secure treatment services on the OPDP for a more treatment-resistant group than those admitted to the DSPD programme. As will be argued in the next chapter, this casts doubt on the extent to which the DSPD programme's successor can be expected to meet the goal of improving mental health outcomes for this group. It further indicates that the DSPD programme has to some extent been co-opted by the criminal justice system.

Chapter 4: The Offender Personality Disorder Pathway[3]

1. Introduction

In the first two chapters of this thesis, it was argued that the DSPD proposals emerged as a policy response to past failures in the management of difficult personality disordered offenders spurred on in part by high profile cases that provoked public fears about the release of dangerous individuals. The subsequent pilot DSPD programme was an experiment designed to balance the interests of the individual and society by offering an intensive course of treatments aimed at improving offenders' mental health and reducing their risk of reoffending while also facilitating their preventive detention in prison or hospital. It also aimed to improve the management of a disruptive group of patients and prisoners and reduce the costs associated with the use of CSCs and segregation units. In its early years, however, the DSPD programme failed in part to live up to these expectations and the effectiveness of the treatment interventions in reducing risk remains unproven. This chapter addresses the reforms undertaken in the name of the Offender Personality Disorder Pathway (OPDP), which has come to replace the DSPD programme.

The OPDP proposals ostensibly build on learning from the DSPD programme and, at first glance, appear to be a more concerted effort to follow through on its original aims and methods. On closer examination, however, it emerges that the plans uncouple the goal of enhancing wellbeing from that of reducing risk. The extent to which the plans follow on from the original vision of the early "DSPD programme evangelists" (Peay 2011a, p.238) may therefore be questioned. Furthermore, the OPDP in high security settings focuses on those prisoners who are least likely to be motivated for treatment and the more treatment-seeking patients and prisoners who gained access to the DSPD programme may find themselves outside of the OPDP. This casts doubt on the capacity for the new OPDP to meet its stated aim of reducing health inequalities. The changes introduced by the OPDP will be examined here with a view to tracing these shifts and drawing out the implications of the policy for personality disordered offenders. The discussion in this chapter will set the scene for an in-depth analysis of the interactions

[3] Parts of this chapter have been taken from O'Loughlin, A. (2014) "The Offender Personality Disorder Pathway: Expansion in the Face of Failure?", *Howard Journal of Criminal Justice* 53(2), 173 – 192.

between law and policy governing the detention, punishment and treatment of personality disordered offenders in the second half of this thesis.

2. Reforming the DSPD Programme

(a) The Offender Personality Disorder Pathway

(i) Changing contexts

The OPDP was devised by civil servants in the Department of Health and the National Offender Management Service (NOMS). NOMS was formed in 2004 in response to the recommendations of the Carter Review, which called for a move away from incapacitating offenders and towards rehabilitating them in the fight against reoffending (Carter 2003, p.15-16). In 2007, it became an executive agency of the Ministry of Justice, which took over responsibility for prisons and probation from the Home Office. The aim of NOMS was to develop "a system focused on the end-to-end management of offenders throughout their sentence" that has "a clear responsibility for reducing re-offending" (Carter 2003, p.34). Its operating principles include the "risk-assessed use of scarce resources, through the use of a system based on improved information" and "more effective service delivery […] through greater contestability, using providers of prison and probation from across the public, private and voluntary sectors" (Carter 2003). In a parallel development, the NHS took over responsibility for prisoner healthcare from the Prison Service with the aim of giving prisoners "equivalence of care", defined as "access to the same quality and range of health care services as the general public receives" (NHS Executive and HM Prison Service 1999, para. 9). Together, these structural changes paved the way for a reconsideration of how offenders with mental health problems were dealt with by the criminal justice and health systems.

By 2006, the NHS had taken over responsibility for prisoner healthcare in the bulk of the prison estate. This brought about some improvements but concerns regarding the inadequacy of prison mental health in-reach services, the detrimental effects of imprisonment on mental health and the high prevalence of mental disorders amongst prisoners persisted. In 2007, the Secretary of State for Justice commissioned a review by Lord Keith Bradley to examine the extent to which offenders with mental health problems or learning disabilities could be diverted from the criminal justice system and

to make recommendations to the government on how to improve mental healthcare provision (Bradley 2009). The subsequent Bradley Report noted that personality disorder was particularly prevalent amongst prisoners, affecting around 63% of the prison population compared to between 10% and 13% of the general population. Rates were particularly high amongst violent and sexual offenders (Bradley 2009, p. 108). For Lord Bradley, this suggested "that in the spirit of 'equivalence of services' some development of personality disorder-specific services would play a significant role in improving prison mental health services" (Bradley 2009, p.108).

The Bradley Report noted the work done by the DSPD programme "at the severe end of the spectrum" but found there was no "coherent and agreed inter-departmental approach to the management of personality disorder within the criminal justice and health systems" (Bradley 2009, p. 109). Consequently, the Report called for an evaluation of the DSPD programme "to ensure that it is able to address the level of need" (Bradley 2009, p. 109). In addition, it recommended that the Department of Health, NOMS and the NHS "develop an inter-departmental strategy for the management of all levels of personality disorder within both the health service and the criminal justice system, covering the management of individuals with personality disorder into and through custody, and also their management in the community" (Bradley 2009, p. 109).

The Conservative-Liberal Democrat Coalition government elected in May 2010 responded to the recommendations of the Bradley Report in a criminal justice consultation paper entitled *Breaking the Cycle*, published in December 2010 (Ministry of Justice 2010a). In acknowledgement of their "joint responsibility" for personality disordered offenders, the NHS and NOMS were to "reconfigure existing services in secure and community settings to manage and reduce risk of reoffending" (Ministry of Justice 2010a, para. 126). Notably, and in contrast to the Bradley Report, there was no reference in *Breaking the Cycle* to plans to improve health outcomes. In February 2011, the Coalition followed up on its commitment with a joint Department of Health and NOMS (2011a) consultation paper putting forward plans for the OPDP.

(ii) Continuity?

Under the plans for the OPDP, the high and medium secure hospital DSPD units were to be decommissioned and treatments for personality disorder on the new pathway would in principle be delivered in the criminal justice system. Resources recouped from

the hospital units would be funnelled into 570 new treatment places and 820 progression places (Department of Health and NOMS 2011a, para. 33). There would also be a programme for identifying prisoners with personality disorder early in their sentences and greater supervision on release. New personality disorder intervention and treatment services were to be established in Category B and C prisons for men, in closed prisons for women and in the community (Department of Health and NOMS 2011a). Onward progression pathways for patients and prisoners from personality disorder treatment units were to be clarified and transfer from treatment units into other parts of the prison and secure hospital estate would be via specialist progression units called "psychologically informed planned environments" (PIPEs) (Department of Health and NOMS 2011a, para. 47). There were also plans for workforce development and a Knowledge and Understanding Framework (KUF) to enhance staff training in personality disorder (Department of Health and NOMS 2011a, para. 41).

In contrast to the pilot DSPD programme, which benefitted from the availability of large sums of money at a time of economic prosperity, the OPDP reforms were undertaken at a time of severe budget cuts. By October 2010, the deficit of Britain's public sector budget stood at £7.1 billion (Office for National Statistics 2010) and a Spending Review announced public sector spending cuts of £81 billion over four years (HM Treasury 2010, p.16). Under the plans, the Ministry of Justice was to lose 23% of its budget (HM Treasury 2010, p.56). Overall, the OPDP strategy was intended to provide interventions for a greater number of offenders using the same resources as the DSPD programme (see Department of Health 2011).

The DSPD programme was originally intended to "develop care pathways to allow a continuum of care across all levels of security" (Department of Health *et al.* 2003) and staff training and development were always part of the plans (see Home Office and Department of Health 1999). In many respects, the OPDP therefore represents a more concerted effort to follow through on the original aims and methods of the DSPD programme. Like its predecessor, the OPDP also seems to be predicated on the assumption that personality disorder and offending are linked and treatment can therefore be expected to reduce risk of reoffending. The "main objective" of the OPDP is "to improve public protection" but it is also expected to contribute to other "strategic objectives" of the Ministry of Justice and the Department of Health. These include "reducing reoffending, improving psychological health and well-being and tackling

health inequality" (Department of Health and NOMS 2011a, para. 36). However, the questionable continuity between the DSPD programme and the OPDP calls into question the extent to which the OPDP proposals follow on from the high aspirations of the DSPD programme's initiators.

As outlined in Chapter 2, Jack Straw's public attack on psychiatrists and the misinformation surrounding the Michael Stone case contributed to a sense that "untreatable" dangerous psychopaths were left free to kill in legal limbo. Perhaps surprisingly, many of the myths and misinformation that were rife at the time the proposals were being discussed live on in the minds of those involved in the OPDP. Despite the findings of the inquiry into his care and treatment (Francis *et al.* 2006), the claim that Stone was "a diagnosed psychopath who did not satisfy the treatability criteria of the 1983 Mental Health Act and who could not therefore be detained indefinitely, constituting an unacceptable risk to the public" was cited recently as one of the reasons for the establishment of the DSPD programme (Lloyd and Bell 2015, p.2).

The introduction to a Special Edition of the *Prison Service Journal* entitled *Working with People with Severe Personality Disorder* published in March 2015 states that in the late 1990s "personality disorder was 'a diagnosis of exclusion' across the NHS" , "there were no services in place and personality disordered patients were largely deemed to be untreatable" (Lloyd and Bell 2015, p.2). Similarly, in the same issue, the officials responsible for designing and commissioning the OPDP claim that, before the DSPD programme, "many offenders perpetrating serious violence and sexual crimes were said to be untreatable" (Benefield *et al.* 2015, p.4). As these individuals' problems were largely "due to behavioural difficulties and/or psychopathy and personality disorder" there was "no place for them in a hospital" (Benefield *et al.* 2015, p.4). It is further claimed that this was the case "for anyone showing signs of personality disturbance whether they were an offender or not" and "left mental health services almost exclusively for those deemed mentally ill" (Benefield *et al.* 2015, p.4).

These blanket statements appear inaccurate given evidence that patients detained on the grounds of psychopathic disorder had long been cared for by the special hospitals (Butler 1975; Dell and Robertson 1988; Fallon 1999). It also disregards the history of the use of psychological interventions with personality disordered patients and the range of opinions amongst psychiatrists and other mental health practitioners as to whether or

not personality disorder or psychopathy could or should be treated in hospital (Butler 1975; Fallon 1999). As Tony Maden commented in his account of the "antecedents and origins" of the programme, "the DSPD diagnosis and service appeared suddenly but not from nowhere" (Maden 2007, s.8). As the key players behind the original DSPD proposals moved on, however, their narrative appears to have become lost in the midst of media and political presentations of the initiative.

(b) The "Rehabilitation Revolution"

In addition to introducing plans to reform the DSPD programme, *Breaking the Cycle* outlined the Conservative-led Coalition's plans to reduce costs and reoffending in a climate of economic austerity. In a speech in June 2010, then Lord Chancellor Ken Clarke broke with the previous Conservative government's claim that "prison works" (Howard 1993) and set a new tone by roundly criticising prison as a "costly and ineffectual approach that fails to turn criminals into law-abiding citizens" (Clarke 2010). Backtracking on the Conservatives' election pledge to top Labour's prison-building scheme by 5,000 new places (Conservative Party 2008, p.16), Clarke vowed instead to close several prisons and reduce prisoner numbers by 3,000 over four years (Clarke 2010). He also foreshadowed plans for a "radical new approach to rehabilitation" that would make prisons not only "places of punishment, but also of education, hard work and change" (Clarke 2010). The Coalition's "rehabilitation revolution" (Ministry of Justice 2010a, p.1) was not as radical as it was portrayed to be, however, as the plans in many ways followed on from the Carter Review (2003) commissioned by its predecessor.

As outlined in Chapter 2, Minister Paul Boateng claimed that society had "both a right and a need to protect itself from the actions of [the DSPD group] who, because of their disordered personality, pose[d] an unacceptable level of risk of causing serious harm to others" (Boateng and Sharland 1999, p.6). In *Breaking the Cycle*, the Coalition made a similar claim in relation to all offenders, asserting that "law abiding citizen[s]" had a "right" "to feel safe in their home and in their community" (Ministry of Justice 2010a, p. 1). Those who threatened that safety would "face a swift and effective response" from a criminal justice system responsible for "punishing offenders, protecting the public and reducing reoffending" (Ministry of Justice 2010a, p. 1). This indicates that the Coalition's approach to rehabilitation is based on similar premises to the DSPD

programme and also assumes a "right" on behalf of a vulnerable public to a subjective sense of security (Ramsay 2012a; 2012d; see also Zedner 2003).

The plans in *Breaking the Cycle* are couched in notably more coercive and punitive language than the DSPD proposals. In the 1999 Green Paper, individuals assessed as DSPD were to be "helped and encouraged to co-operate in therapeutic and other activity designed to help them return safely to the community" (Home Office and Department of Health 1999, p.9). However, it was clear that if treatment did not succeed in reducing the risks they presented, there would be "no alternative but to continue to detain them indefinitely if the public is to be properly protected" (Home Office and Department of Health 1999, p.9). While not expressed in these terms, the figurative bargain struck between the government and the DSPD group appeared to give rise to a duty for the latter to take up the opportunities offered to them in the form of treatment and, through these means, prove their safety for release. In *Breaking the Cycle*, the Coalition government asserted more explicitly that "offenders who commit to reforming themselves will have a greater chance of returning to society as law abiding citizens" (Ministry of Justice 2010a, para. 29). For the Coalition, "managing offenders" meant "striking the right balance between controlling them to protect communities and requiring them to take the action needed to change their criminal lifestyle" (Ministry of Justice 2010a, para. 84). The nature of the offender's duty to engage in rehabilitation and the coercion that underlies it is analysed in further detail in the next chapter of this thesis.

In *Breaking the Cycle*, punishment was also conceived of as a means of reducing reoffending, as exemplified by the claim that the government's plans were "about finding out what works – the methods of punishment and rehabilitation [that] actually reduce crime by reducing the number of criminals" (Ministry of Justice 2010a, p.2). The Ministerial forward to the OPDP consultation also stated that "having a personality disorder does not absolve responsibility for criminal behaviour, and all offenders will be held accountable for their actions" (Department of Health and NOMS 2011a, p.5). This reflects the legal view of personality disordered offenders as criminally responsible and deserving of punishment despite their limited volitional and rational capacities (see Chapters 5 and 6).

As noted previously, one of the aims of NOMS was to increase efficiency in the management of offenders by opening the provision of prison and probation services up to competition. In *Breaking the Cycle*, the Coalition declared its intention to pursue the marketization of criminal justice services. This drive has continued in the more recent *Transforming Rehabilitation* agenda (Ministry of Justice 2013a). The government is concerned not to "take any risks in protecting the public", however, and the public sector National Probation Service (NPS) is to "retain ultimate responsibility for public protection and […] manage directly those offenders who pose the highest risk of serious harm to the public" (Ministry of Justice 2013a, p. 6). The reformed NPS was established on 1st June 2014 along with 21 Community Rehabilitation Companies managing low to medium risk offenders (National Probation Service 2015). As will be seen further below, part of the criteria for admission to the OPDP requires offenders to be managed by the NPS.

Despite some similarities, the OPDP departs from the original approach of the DSPD programme in a number of important ways. The most surprising element of the plans is that the selection of prisoners for the OPDP will no longer require a "formal" diagnosis of personality disorder (Department of Health and NOMS 2011a, para.17). The new scheme will be located predominantly within the criminal justice system and aims not only to facilitate the progression of prisoners onwards from high security settings but will also incorporate prisoners from lower security categories. The OPDP also represents a lowering of expectations for treatment and an increased focus on identifying and monitoring the risks presented by offenders. Nevertheless, the treatment programmes on offer incorporate more holistic understandings of personality disorder that imply that enhancing the wellbeing of offenders continues to be an aim of the OPDP. The remainder of this chapter will consider each of these changes in turn and highlight their implications for personality disordered offenders and the prospects for the OPDP to succeed in meeting its aims.

3. A Criminal Justice Pathway

(a) Are prisons "more effective"?

Under the OPDP, treatment for personality disorder will primarily take place in prisons but transfer to hospital will be available in certain circumstances. The Coalition's strategy ostensibly aims to improve services for personality disordered offenders by diverting resources away from the hospital system and investing them in prisons, where "treatments can be provided more effectively and at much lower cost" (Department of Health and NOMS 2011a, para.2). As noted in the previous chapter, however, the IDEA study reported little difference between the DSPD hospital and prison units in terms of treatment effectiveness (Burns *et al.* 2011). Both patients and prisoners experienced weak but statistically significant reductions in VRS scores (Burns *et al.* 2011). The claim that treatments can be provided "more effectively" in prison may therefore be questioned.

At first glance, the prison DSPD units appeared to outperform the hospital units in terms of patient satisfaction. While both groups were dissatisfied with the time spent "waiting" for treatment, those in the hospital units expressed the greatest discontent (Burns *et al.* 2011). There were also fewer violent incidents recorded in prisons than in hospitals, indicating that the DSPD group may have been managed more smoothly by the prisons. On closer examination, however, a significant number of patients were being preventatively detained in the hospital DSPD units following the expiry of their determinate prison sentences. The corollary of this was that a greater proportion of DSPD patients than prisoners felt that they had little say in their admission to the programme and patients reported a higher level of perceived coercion than prisoners (Burns *et al.* 2011, p.225; p.58). This is significant, particularly given the IDEA study's finding that unwillingly-admitted patients were less motivated to participate in treatment (Burns *et al.* 2011). The hospital patients may therefore have been more difficult to manage and work with than the prisoners. On the other hand, the IDEA study reported that some hospital patients seemed to adopt a "sick" role with a sense of entitlement to treatment (Burns *et al.* 2011, p.231). The disappointment that such patients felt at the low number of treatment hours may also have contributed to their dissatisfaction. As will be seen below, the latest criteria for entry onto the OPDP appear to exclude more treatment-seeking prisoners, casting doubt on the extent to which the programme can be expected to tackle health inequalities in the spirit of the Bradley Report (2009).

While the claim that the prison units were "more effective" than the hospital units is not supported by the IDEA findings, what is clear is that the prisons were providing similar treatments to the DSPD group at a much lower cost than the hospitals. The annual operating costs of the DSPD programme were huge, estimated at £69 million per annum. At approximately £300,000 per year, a place in a secure psychiatric DSPD unit cost over three times as much as a place in a prison DSPD unit, at £85,000 per year (Department of Health and NOMS 2011a, para.24). From the available data it appears that the extra cost did not equate to better results. At a time of severe budget cuts, it seems that concern with cost, rather than effectiveness or appropriateness, may have been the determining factor in the decision to focus on a prison pathway.

Secure hospitals will, however, continue to play a role on the OPDP. The former DSPD units are to become hospital PD units funded through NHS England Specialised Commissioning, and high and medium secure personality disorder treatment services in hospitals will be part of the pathway approach (Department of Health and NOMS 2011a). Placement in hospital will "be reserved for offenders who can only be managed in a hospital setting" (NOMS and NHS England 2015, p.17). Broad criteria for entry onto the hospital pathway include uncertain, changing or disputed diagnosis or risk levels, a need for interventions not readily available in prison, deliberate self-harm, co-morbid mental illnesses requiring stabilisation in hospital, and complexity compounded by borderline intellectual functioning or neurological impairment. Also mentioned are "repeated failure in a prison setting", "irretrievable breakdown of relationships in custody" and "therapy-interfering behaviours" such as "litigiousness, breaches of boundaries [and] pathological attachments" (NOMS and NHS England 2015, p.17). Finally, there are "notional 37s" – patients who were transferred to hospital under s.47 of the MHA 1983 but whose prison sentences have since expired (NOMS and NHS England 2015, p.17).

The criteria indicate that secure hospitals will continue to be used to preventively detain individuals at the end of determinate prison sentences and that they are to take on the more challenging and complex cases that cannot be dealt with by the prison service. Following decommissioning, they will be expected to do this without the additional staffing and resources of the DSPD units. The DSPD unit at Broadmoor closed in April 2012 and 78 staff were made redundant (*Nursing Standard*, April 2012). The Peaks unit at Rampton hospital remained open and operational for a time and accepted patients

from areas in the south of England in order to compensate for the closure of the Broadmoor unit (Nottinghamshire Healthcare NHS Trust 2011). In July 2014, the Peaks ceased to accept DSPD referrals and all subsequent referrals would be categorised as general personality disorder (PD) patients (Nottinghamshire Healthcare NHS Trust and NHS England 2015). The purpose-built Peaks unit is now to become part of the general PD service at Rampton. Of the original cohort of 63 DSPD patients present at decommissioning, 47 remain at Rampton while the others have been moved to other prison or secure hospital accommodation (Nottinghamshire Healthcare NHS Trust and NHS England 2015). Patients who would otherwise have been referred to the Peaks are now to be referred to the prison pathway or to one of three PD wards at Rampton, Broadmoor and Ashworth (DH/NOMS Offender Personality Disorder Programme 2014).

The OPDP is to be evaluated over a period of 4 years in a project led by Paul Moran of King's College London. The first phase, a feasibility study, started in August 2014. This will be followed by a process study, impact evaluation and economic evaluation. The whole study is expected to be completed in 2018. The impact evaluation will measure the effectiveness of the pathway in "reducing reoffending and improving psychological health" (NOMS and NHS England 2015, p.18-19). Given the large and diffuse nature of the pathway, however, it is likely to prove challenging to evaluate. Furthermore, at four years, the timeframe for the study is very short and it is unlikely that it will be possible to draw robust conclusions on treatment effectiveness. It has also been commissioned very early given that the plans for the OPDP were first announced in 2011. Thus, the evaluation may suffer from the same difficulties as those that faced the IMPALOX and IDEA studies considered in the previous chapter. A follow-up study of the progress of the DSPD cohorts may provide more convincing conclusions on effectiveness but there are no plans to do so at present. This raises the concern that the evaluation of the OPDP may not bring us much closer to determining "what works" in reducing risk of reoffending amongst personality disordered offenders.

(b) Can prisons be therapeutic?

As noted in previous chapters, the question of where dangerous offenders with personality disorder or psychopathy should be detained, treated and managed has been a significant point of debate (see Butler 1975; Fallon 1999; Reed 1994). This debate is

on-going and has not been resolved by the decision by those behind the OPDP to opt for a system focused on prison and probation seemingly on grounds of cost. A group of psychiatrists at Broadmoor hospital have argued that the diagnostic expertise of doctors is needed to assess a group of patients who often present with complex psychopathologies and mental illnesses in addition to personality disorder so that they may be directed towards suitable treatment (Witharana *et al.* 2011). In a similar vein, Howells and colleagues refer to the "untold story" of the benefits of psychotropic medications which help to "stabilize individuals so that they can then engage in psychological and lifestyle-focused interventions" (Howells *et al.* 2011, p.130). More radically, Lawrence Jones, a psychologist and former clinical lead of the Rampton DSPD unit, proposes that severe personality disorder may be better conceptualised as chronic trauma given the histories of abuse and victimisation common to those in the DSPD group. Intervening with some patients in a prison setting may be inappropriate or even unethical due to the potential for patients to be re-traumatised (Jones 2015).

The above raises the broader question of whether prisons can act as therapeutic environments. There is evidence from the broader sociological literature that the demands of prison are not compatible with the goal of rehabilitation, and particularly with holistic rehabilitation programmes, such as the DSPD programme, that require changes in the prison environment and culture. For example, Elaine Genders and Elaine Player (1995; 2010) found in their study of the TC at HMP Grendon that where a conflict arose between the interests of the mainstream prison and the TC, penal power tended to prevail. Richard Sparks' (2002) experience of the Barlinnie Special Unit in Scotland also yields evidence of conflict between the agenda of the wider prison and that of the "experimental" Special Unit with its permissive TC, which was eventually closed. The OPDP documentation implicitly recognises this conflict, particularly in its plans for PIPEs. These units are intended to provide "a safe and facilitating environment that can retain the benefits gained from treatment, test offenders to see whether behavioural changes are retained and support offenders to progress through the system" (Department of Health and NOMS 2011a, para.59). This implies that a return to mainstream location risks undoing the progress made in therapy and, by extension, that the prison environment, at least in its current form, is not supportive of lasting change.

Evaluations of both the DSPD units (Trebilcock and Weaver 2010b) and a PIPE pilot (Turley *et al.* 2013) give indications of conflict between experimental treatment and

progression units and the culture and priorities of security staff. According to the PIPE evaluation, while relationships between staff and prisoners were generally described as positive, some prison officers found it difficult to adjust to the ethos of the PIPE as they were required to address inmates by their first names and to participate in therapeutic and leisure activities alongside them (Turley *et al.* 2013). Similarly, prison officers at the DSPD unit at HMP Whitemoor were wary of the therapeutic model at first as they felt it threatened the smooth management of the prisoners and generated risks to the safety and security of staff (Fox 2010). This tension was eventually resolved as officers came to see that, by challenging the prisoners, the programme was working towards reductions in risks to the public in the long-term. In this context, they became more tolerant of the short-term risks to safety and good order provoked by treatment (Fox 2010). The need for officers to "emotionally engage" (Fox 2010, p.230) with prisoners as part of the therapeutic model was also problematic, as officers in training are "informally encouraged to 'develop a suspicious mindset'" and never to trust or become friends with prisoners (Fox 2010, p.229, citing Crawley 2004). Prison officers who embraced their new role were treated with suspicion by colleagues both within and beyond the DSPD unit who disapproved of "caring" for prisoners (Fox 2010).

Conflicts between the units and their host institutions were also apparent. The schedule of the PIPE often conflicted with that of its host prison and there was evidence that the PIPE became insular and residents tended to stick together when out in the main prison. Similar problems were experienced by the DSPD units. Prisoners and patients interviewed by the IDEA team commented that security procedures interfered with the therapeutic aims of the DSPD units (Burns *et al.* 2011, p.215-217) and staff interviewed by MEMOS spoke of conflicts between the units and their host institutions. Sources of tension included the greater resources and higher staffing levels of the DSPD units, their relative isolation, the security policies of the wider institution restricting the extent to which the DSPD units could operate in line with their clinical models, and misunderstandings in the wider institution about the work of the DSPD unit (Trebilcock and Weaver 2010b). These tensions eased over time through efforts on behalf of management to improve the integration of DSPD units with their host institutions, to raise awareness of the work of the DSPD units within the institution and to encourage the sharing of best practices (Trebilcock and Weaver 2010b). However, practitioners in

the former DSPD prison units revealed in interview that while there had been some improvement, tensions with their host prisons required on-going negotiation.

These tensions and role conflicts indicate that broader cultural changes will be required before prisons can become more therapeutic places. One of NOMS's six "commissioning intentions" from 2014 is to "enhance public protection and ensure a safe, decent environment and rehabilitative culture" in prisons (NOMS 2013 p.9). According to a recently released Rehabilitation Services Specification, the "right prison culture" is one in which "prisoners feel safe and hopeful and where constructive staff prisoner relationships promote desistance, recovery, rehabilitation and change" (NOMS 2015, para. 4.3). While these changes sound positive, it is questionable whether they can be achieved in the current climate. Prisons will be "expected to provide" therapeutic environments "using their own staff resources" (NOMS 2015, para. 1.4). In other words, no additional funding will be available. Reports of increased incidences of suicide, self-harm and assault in prisons demonstrate that the system is already struggling to cope with cuts to staff and chronic overcrowding (see Howard League for Penal Reform 2014; HM Chief Inspector of Prisons for England and Wales 2014). Furthermore, the delivery of therapeutic interventions in the coercive prison environment may be expected to undermine their effectiveness and lead to greater punishment for personality disordered prisoners. These tensions will be explored further in Chapter 7 of this thesis.

4. Progression and Expansion

As illustrated in previous chapters, the DSPD proposals were a compromise between the interests of the Department of Health and the Home Office. In the OPDP proposals, on the other hand, the concerns of the Ministry of Justice are much more prominent and health considerations appear to be marginalised. This is evident from the expansion of the OPDP into lower security categories and the lowering of expectations for treatment, discussed below.

(a) Progression

The OPDP places particular emphasis on prisoner progression and proposes a "whole systems approach", incorporating "the various stages of an offender's journey, from

charge, conviction, prison, [to] post release supervision and resettlement" (Department of Health and NOMS 2011a, para. 38). The pathway will also integrate outcomes from "related programmes for young people and families […] to contribute to breaking the intergenerational crime cycle" (Department of Health and NOMS 2011a, para. 38). In this sense, the OPDP seems closer to the original plans for the third service, which, according to one early policymaker, would have been "end-to-end" or "cradle to the grave" (Civil Servant). Rather than establishing a separate service, however, the OPDP operates within existing legal and institutional structures.

As seen from earlier chapters, the DSPD programme was originally intended to incorporate "step-down" for patients and prisoners from high secure services. Treatment interventions were also intended to be short term and intensive so that they could reach a larger number of offenders. The reality was much slower movement and longer stays. Due to an initial focus on the "high end" of the system, the options for onward progression were limited and uncertainties regarding pathways out of the units also had a detrimental effect on prisoner and patient engagement with therapy (Trebilcock and Weaver 2010a; 2010b; Burns *et al.* 2011). The OPDP aims to resolve these issues by developing new treatment units in Category B and C prisons for men and closed prisons for women and establishing a number of PIPEs in prisons and the community.

(b) Expansion at the bottom

The 2011 consultation document on the OPDP proposed the following inclusion criteria for the pathway:

> The pathway is intended to meet the needs of all offenders […] who have a severe personality disorder; *and*
>
> - are assessed as presenting a high likelihood of violent or sexual offence repetition;
> - present a high or very high risk of serious harm to others;
> - *and where* there is a clinically justifiable link between their psychological disorder and the risks they pose (Department of Health and NOMS 2011a, para. 16. Original emphasis).

By replicating the DSPD criteria almost exactly, the OPDP initiative at first appears to be based on the same assumptions as its predecessor: that personality disorder causes

offending and that treatment for personality disorder will therefore reduce risk of recidivism. Upon further examination, however, it emerges that the OPDP criteria are more flexible than the original DSPD criteria and may be applied less strictly. Startlingly, despite the inclusion of "severe personality disorder" in the criteria, the OPDP consultation document notes that the "focus of work, in most cases, will be in relation to offenders who do not have a formal personality disorder diagnosis" (Department of Health and NOMS 2011a, para. 17). These individuals "will have complex needs consisting of emotional and interpersonal difficulties, and display challenging behaviour of a degree that causes concern in relation to their effective management" (Department of Health and NOMS 2011a, para. 17). A formal diagnosis will be required for "some forms of treatment" on the OPDP, but it is not specified what these might be (Department of Health and NOMS 2011a, para. 17).

More recently published criteria for entry onto the OPDP for men are even broader. The pathway will be open to men:

1. At any point during their sentence, assessed as presenting a high likelihood of violent or sexual offence repetition and as presenting a high or very high risk of serious harm to others; and
2. Likely to have a severe personality disorder; and
3. A clinically justifiable link between the personality disorder and the risk; and
4. The case is managed by [the National Probation Service] (Benefield *et al.* 2015, p.6).

"Severe personality disorder" is also characterised as:

> Persistent and complex needs with regard to interpersonal functioning; emotion regulation; arousal; impulse control and ways of thinking and perceiving. It is associated with considerable personal and social disruption. The disorder is likely to appear in late childhood or early adolescence and is enduring (d'Cruz 2015, p.49).

This definition does not adhere to any particular type of personality disorder recognised in current clinical classifications such as the DSM-V and ICD-10 and therefore appears to have even less scientific validity than the original DSPD criteria. The reference to a

"psychological disorder" rather than a "personality disorder" indicates the potential breadth of application of the OPDP criteria beyond the small group targeted by the early DSPD policymakers. Given the uproar over the controversial DSPD "diagnosis" noted in Chapter 2 it is perhaps surprising that the criteria for the OPDP have received such little attention. Given the substantial overlap between the diagnostic criteria for psychopathy, ASPD and BPD and offending behaviour and the high rates of ASPD and BPD reported in the prison population, the generality of the OPDP criteria also raises the question of what exactly distinguishes severely personality disordered individuals from other high risk offenders who pose management problems in prisons.

As highlighted in previous chapters, the developers of the DSPD programme sought to alleviate public fears and dispel the "myth" that anyone with a personality disorder could be swept up off the streets and detained against their will. One of their first tasks was therefore to make clear that the programme would be reserved for a small number of serious offenders. Initial estimates of numbers eligible for the DSPD programme were accordingly very low, at around 2,000 (Home Office and Department of Health 1999; Boateng and Sharland 1999). At around 20,000, the number of men expected to be eligible for the OPDP is ten times higher (Benefield *et al.* 2015, p.4). The total NOMS caseload figure from which this calculation derives is not given. Based on NOMS statistics, the total male prison and probation caseload was 276,532 men on 31 December 2014 (Ministry of Justice 2015a, Table A4.13; Ministry of Justice 2015b, Table 1.1). The estimated male OPDP population is therefore approximately 7.2% of the total NOMS caseload.

There are a number of possible explanations for the significant upsurge in numbers. As the pathway will include offenders who have been assessed as high risk "at any point during their sentence" (Benefield *et al.* 2015 p.6) it may be expected to draw many more individuals into the net. The inclusion of prisoners "likely" to suffer from a personality disorder also accounts for part of the increase. Another possible area for slippage is the third criterion of a "link" between the personality disorder and risk of reoffending. This is now described as a "clinically justifiable link" (Benefield *et al.* 2015 p.6). However, no further information is available on how this link is to be evaluated or justified in light of the fact that a "formal" diagnosis of personality disorder will not be necessary.

As noted in the previous chapters, the idea of a "link" between personality disorder and risk of offending in the original DSPD criteria was controversial and it was not clear whether this criterion required causation or merely co-occurrence. Given the small numbers estimated to be eligible for the DSPD programme, Conor Duggan and Richard Howard (2009) concluded that the narrower causal interpretation must have been intended. In light of the vast increase in numbers eligible for the OPDP, it may be that the "link" now merely requires co-occurrence. This criterion may no longer operate to exclude prisoners from the pathway, which may simply incorporate any serious offenders who are difficult to manage in prison.

A seemingly progressive move under the OPDP is the removal of the stigmatising "dangerous and severe" label. However, stigma also attaches to the personality disorder label itself (Tyrer *et al.* 2011). A group of psychiatrists at Broadmoor have expressed concern that diagnosis and case formulation under the OPDP will be left to offender managers with the assistance of forensic and clinical psychologists with no medical input, and assessment may be based on filling out a form rather than a comprehensive clinical assessment (Witharana *et al.* 2011). This, in their opinion, could lead to an over-diagnosis of personality disorder and the attachment of a stigmatising label that can affect a patient's care pathway and subsequent sentencing and custody decisions. On the flipside, it may also result in under-diagnosis, with some personality disordered individuals slipping through the net and being left out of services that could be of benefit to them.

The incorporation of individuals who have not been formally diagnosed with personality disorder into a "personality disorder pathway" explicitly linked with high risk of serious harm is problematic. The continuing uncertainty about treatment may mean that a stigmatising label will be attached to prisoners without giving them effective means to later remove it. Furthermore, inclusion on a pathway for high risk offenders may potentially be a retrograde step for prisoners whose security categorisation has been downgraded due to reduced risks over the course of their sentence. The expansion of the OPDP to prisoners in lower security categories thus risks impeding the progress of ever greater numbers of prisoners and may subject them to increased punishment, as considered further below.

(c) Narrowing at the top

The 2011 consultation document specifies additional criteria for entry into personality disorder units in Category A prisons, "most" of which should be met before admission (Department of Health and NOMS 2011a, para. 49). These include offence and risk-related criteria such as posing "an imminent risk of serious harm to others if released" and "a history of serious violent and/or sexual offences" which "may have excessively violent or sadistic aspects" (Department of Health and NOMS 2011a, para. 49). Other criteria relate to offenders' personality traits or behaviour. These include failing to acknowledge the harms they have caused, tending to minimise the impact of their offending on others, blaming others for their problems or circumstances, exploiting others and abusing trust or friendships, and a history of breaching parole, bail conditions or community sentences (Department of Health and NOMS 2011a, para. 49). Further criteria relate to their motivation or amenability to treatment, including being "unlikely to make progress in other interventions", requiring "more intense intervention from psychologically trained staff" and being "unlikely to be very motivated, but likely to benefit from work to increase […] motivation and engagement" (Department of Health and NOMS 2011a, para. 49). Prisoners must have a minimum of three years to serve on their sentence and priority will be given to those who have spent time in segregation or who are ready to leave a CSC (Department of Health and NOMS 2011a, para. 49).

The new criteria may be expected to yield a more concentrated population of prisoners exhibiting antisocial or psychopathic personality traits and behaviours than those admitted to the high secure DSPD units. These prisoners are likely to prove exceptionally difficult to work with given that they will be selected explicitly on the grounds of their low motivation to engage with treatment. It is not clear how their likelihood of responding to interventions to increase motivation will be determined before entry to the programme. The concentration of treatment resistant prisoners makes it likely that these units will be particularly difficult to manage and may struggle with staff retention and motivation. This indicates that some important lessons from the DSPD programme may not have been learned and that the OPDP may therefore be expanding "in the face of failure" (O'Loughlin 2014).

The changes are problematic on another level, as entry to the high security units will not require the consent of the prisoner and an element of implicit coercion will therefore be present. This may jeopardise the effectiveness of psychological treatments. The decision to focus on the antisocial type in high secure services also presents difficulties in terms

of "equivalence of services" for all prisoners with personality disorder (Bradley 2009, p.108). As outlined in the previous chapter, some patients and prisoners on the DSPD programme had PCL-R scores under the threshold for psychopathy and over half had been diagnosed with BPD. These patients may have been more treatment-seeking and possibly more amenable to treatment given the more encouraging evidence base for treating BPD (NCCMH *et al.* 2009). Such prisoners may now be excluded from high secure units focusing on those with a more antisocial profile. The aim of "reducing health inequalities" is also problematic in relation to offenders diagnosed with ASPD, as success in treating this population is often calculated in terms of reduced risks to others rather than benefit to patients (NCCMH *et al.* 2010). Prisoners with low motivation for treatment may be even less likely to engage with treatments primarily aimed at reducing risk to the public. Again, the extent to which the OPDP builds on learning from the DSPD programme may be questioned given the disruption caused to the work of the units by patients who were resisting treatment.

(d) Women's services

As outlined in the previous chapter, the assessment criteria for entry onto the DSPD programme for women were identical to those for men except for the diagnostic criteria, which required lower PCL-R scores and higher levels of comorbidity (see DSPD Programme *et al.* 2006, p. 8). At around 50, the number of women expected to meet the DSPD criteria was very low and just 12 treatment places for women were established at the Primrose Unit at HMP Low Newton (DSPD Programme *et al.* 2006, p.8). For the OPDP strategists, applying the same criteria to women as to men would have yielded a group too small for a viable pathway and would have failed "to fill the yawning gap between the level of need and the availability of interventions for women who do not necessarily present a risk of harm to others, but who have significant personality difficulties linked to their offending" (d'Cruz 2015, p. 48). Separate criteria were therefore devised for the OPDP "to ensure equality of access to services for women" by reflecting "the much *lower* numbers of women who are a high risk of harm to the general public, and the proportionately *higher* numbers of women offenders with mental health problems and self-harming behaviours" (Benefield *et al.* 2015, p.6. Emphasis in original).

The new criteria are much broader than the original DSPD criteria for women:

1. Current offence of violence against the person, criminal damage, sexual (not economically motivated) and/or against children; and
2. Assessed as presenting a high risk of committing an offence from the above categories OR managed by the NPS; and
3. Likely to have a severe form of personality disorder; and
4. A clinically justifiable link between the above (d'Cruz 2015, p.49).

The first criterion requires women to have an index offence from a specific range of offences that may fall below the threshold of "serious harm" set by the OPDP criteria for men. The inclusion of the offence of criminal damage without any additional requirement of harm to others may be expected to widen the net considerably. No further explanation is given for the inclusion of this offence or for the reference to offences against children. Another difference is the requirement that the woman should present a high risk of committing a further specified offence *or* be managed by the NPS, implying that women who do not reach the risk threshold required for management by the NPS may nevertheless enter onto the OPDP.

As may be expected, estimates of the number of women eligible for the OPDP are significantly higher than under the DSPD programme and stand at between 1,000 and 1,500 (d'Cruz 2015, p.48). The upper estimate is 30 times the original figure estimated to be eligible for the DSPD programme for women. According to the latest offender management statistics, the total female probation and prison caseload was 25,518 on 31 December 2014 (Ministry of Justice 2015a, Table A4.13; Ministry of Justice 2015b, Table 1.1.). The upper estimate is therefore approximately 5.9% of the current NOMS female caseload, somewhat lower than the 7.2% figure for men.

Services for women on the OPDP are more explicitly aimed at enhancing wellbeing than those for men. Thus, the aim of the high secure Primrose Service at HMP Low Newton is to "reduce risk to self and others, and to provide women with pro-social life skills which enhance their physical, emotional, spiritual and mental wellbeing" (d'Cruz 2015, p.51). The Corston Report (2007) on women in the criminal justice system called for services to adopt a "woman-centred", holistic approach and the OPDP strategy for women claims to pursue this. However, despite the identification of a "gap" between those presenting the highest risks and those with the greatest needs, the women's strategy still focuses on women assessed as presenting a high risk of relatively serious

reoffending. Lower risk but perhaps more needy personality disordered women may therefore be left out.

(e) Progress?

Julie Trebilcock and Tim Weaver (2010a; 2012a) found in their study of Parole Board decision-making in relation to DSPD prisoners that Parole Board members attached more weight to the high security categorisation of the prisoners than to the DSPD label. Almost by definition, Category A prisoners were unlikely to be recommended for release or transfer to open prison conditions, which were the only options open to the Board in their cases. On the other hand, Parole Board members were concerned by the stigma attaching to the DSPD label, and the DSPD programme was seen to be a disruption to prisoners' expected journeys as it "introduced unknown, unaccredited and individualised treatment interventions into a highly structured system" (Trebilcock and Weaver 2012a, p.148). The implications for assessing risk on such a programme were therefore unclear. The OPDP introduces further unknowns, such as the new PIPEs and treatment units in Category B and C prisons. Like the DSPD programme, these units will have to develop their own treatment programmes and ways of working.

Completing an intervention such as the DSPD programme can be a condition for progressing through prison. One prison practitioner asserted in interview that once prisoners were assessed to be suitable, the DSPD programme would "remain on their sentence plan […] until they access treatment" (Practitioner). DSPD practitioners also made clear in interview that therapy also performs a risk-monitoring function. Information from therapy sessions and informal interactions between inmates and staff are constantly fed into individual prisoner risk profiles maintained by the multidisciplinary team on the units. Similarly, the PIPEs have an explicit risk monitoring function and staff continually test and assess prisoners by observing their interactions (Turley *et al.* 2013). It may be, therefore, that both refusal to engage and participation in therapy feed into judgments on risk and may hinder offenders in their progress towards release. The next chapter will examine further the impact of selection for a treatment programme such as the OPDP on categorisation and release decisions.

Given that participation in the OPDP may impede their progress, prisoners may have rational reasons to refuse to engage with treatment. If they agree to participate, on the other hand, they may find themselves in a Catch-22 as their compliance may be

interpreted as an attempt at manipulation and a manifestation of their disorders (see Lacombe 2007). Viewing prisoners' acts of resistance and compliance with prison regimes through the lens of their disorders draws attention away from the coercive environment in which they find themselves. In this context, a treatment programme that encourages offenders to take responsibility for themselves and make "pro-social choices" (Hannah-Moffat 2005) disguises the ultimately coercive nature of the "bargain" underlying the DSPD programme that is perpetuated by the OPDP. This theme will be returned to in Chapter 7.

5. Expectations for Treatment

(a) Narrower horizons

As noted previously, the OPDP appears to set lower expectations for treatment than the DSPD programme. The promise of the OPDP, according to one interviewee involved in its development, was that it "could make things more effective in terms of output, although not necessarily in terms of outcome" (Civil Servant). This distinction is important, as it shows that aspirations have become narrower. Indeed, as the same interviewee told me, "treatment is the smallest part of our programme". The rationale for this was that around 90% of the typically "treatment resistant" DSPD population would never access treatment but yet would "still present a high risk of harm to others" (Civil Servant). Therefore it made more sense to focus resources on the 90% who were out of treatment rather than on the 10% who were in treatment. It is clear from this that the OPDP will focus more on identifying, monitoring and managing the risks posed by these prisoners than on delivering treatments for the few that engage.

According to the interviewee, by defining people as either in or out of treatment, the OPDP would risk missing "the people with the greatest level of need […] [and] the greatest complexity" and also "the public protection responsibility" (Civil Servant). The latter, the interviewee remarked, was "what Jack Straw's main concern was in the early days. So in some ways perhaps we're closer to meeting those original objectives now than we were 10 years ago" (Civil Servant). This statement stands in contrast to the original aim of the programme as defined by the early DSPD policymakers, which was not only to ensure public protection but also to meet the mental health needs of

individual offenders in exchange for their preventive detention. For one early policymaker, the focus of the OPDP on a criminal justice pathway was disappointing, as "the whole point" of the DSPD proposals "was not to give up on treatment" (Politician). For another, the move indicated that the present policy team are "focusing on narrower horizons [and] redefining what is success, frankly" (Civil Servant).

Part of the reason for the narrower focus of the policy may be that the evidence base for treating personality disorders, particularly ASPD, remains limited (Gibbon *et al.* 2010; Khalifa *et al.* 2010; Stoffers *et al.* 2010; 2012). A review of the evidence base for interventions geared towards reducing reoffending conducted by the Ministry of Justice (2014) as part of the *Transforming Rehabilitation* initiative found that "while mental health problems may be linked to offending behaviour, and there is evidence of a specific link between psychopathy and violent reoffending, any such relationship is likely to be complex and mediated by other factors, such as poverty, poor social environments and difficult family and interpersonal relationships" (Ministry of Justice 2014, p.21). The review noted that there was "limited evidence on interventions targeted specifically at offenders with mental health needs, and it is often inconclusive regarding criminal justice outcomes" (Ministry of Justice 2014, p.21). On the other hand, the review noted there was "good" evidence to support the use of cognitive skills programmes and violence reduction programmes using the risk-need-responsivity model to reduce reoffending amongst violent offenders (Ministry of Justice 2014, p. 22-23). For sexual offenders, however, the evidence remained "mixed", with some reviews unable to draw conclusions on reoffending (Ministry of Justice 2014, p.23-24).

In a context of little robust research, the NICE guidelines on both BPD and ASPD suggest clinicians consider using those interventions that have shown some promise in treating these disorders (NCCMH *et al.* 2009; 2010). While changing personality traits themselves appears to be a difficult task, there is some evidence to support the use of behavioural interventions with offenders. NICE advises practitioners treating offenders with ASPD in institutional and community settings to "consider offering group-based cognitive and behavioural interventions […] focused on reducing offending and other antisocial behaviour" (NCCMH *et al.* 2010, para. 7.2.18.2). In separate guidance for BPD, NICE recommends that clinicians consider "a comprehensive dialectical behaviour therapy programme" where the priority is to reduce self-harming behaviour in women (NCCMH *et al.* 2009, para. 5.12.1.3).

The ASPD guideline also recommends challenging therapeutic pessimism and negative attitudes towards ASPD patients and to encourage staff to develop "a stronger belief in the effectiveness of their own personal skills" (NCCMH *et al.* 2010, para. 4.3.1). For patients with BPD, NICE recommends exploring treatment options "in an atmosphere of hope and optimism, explaining that recovery is possible and attainable" and building a trusting relationship between therapist and patient (NCCMH *et al.* 2009, para. 4.6.2.1). The message in relation to both disorders is therefore one of therapeutic optimism despite a limited evidence base.

The focus on reducing reoffending rather than meeting mental health needs in policy documents seems to indicate that the priorities of the criminal justice system have won out, and those of the health system have retreated. Aspirations for the DSPD initiative seem to have progressively narrowed, from the grand vision for a radical "third service", to an experiment operating as a compromise between the health and criminal justice systems, to what now appears to be an extension of existing prison and probation arrangements. The DSPD story is therefore one of revised expectations, as grand aspirations about treatment have given way to a more narrow pragmatism and concern with protecting the public. A counter-trend may, however, be discerned in the continuing place of holistic and welfare-oriented treatment approaches on the pathway, outlined below.

(b) Treatments on the OPDP

It was noted in the previous chapter that, due to a lack of robust evidence on effective treatments for personality disorder, the DSPD units were encouraged to develop their own treatment models and therapeutic environments. Peter Tyrer and colleagues are critical of this approach and argue that "the programme cannot continue to use what are essentially cottage garden modifications of treatments developed elsewhere, which have not yet demonstrated efficacy in this population" (Tyrer *et al.* 2015, p.102). While the plans for OPDP appear to be moving towards a greater concern with offending behaviour, treatments aimed at altering problematic personality traits themselves retain a place. This indicates that the original ideas of the DSPD "evangelists" (Peay 2011a, p.238) and the (perhaps misguided) notion of a causal link between personality disorder and offending (Duggan and Howard 2009) have not been entirely forgotten.

It is beyond the scope of this thesis to survey the complex array of approaches taken to treating personality disorder on the OPDP, or to examine any one treatment programme in detail. Brief comment is, however, offered here on the approach taken by two treatment programmes: the Chromis programme at HMP Frankland and the cognitive interpersonal model at HMP Whitemoor.

(i) The Chromis Programme at HMP Frankland

The Chromis programme at HMP Frankland draws explicitly on the "risk-need-responsivity" (RNR) model developed by James Bonta and D.A. Andrews (2007). The RNR model is a product of the "what works" movement which advocates the use of "evidence-based" interventions with offenders that have been shown to reduce reoffending (Cullen and Gendreau 2001). Three principles govern the RNR model. First, interventions should target those offenders at highest risk of reoffending (the risk principle). Second, they should focus on criminogenic risk factors or "needs" linked to reoffending (the need principle). Finally, they should be adapted to the learning styles and abilities of individual offenders (the responsivity principle) (Bonta and Andrews 2007). "Criminogenic needs" are risk factors for offending and include antisocial or criminal beliefs or attitudes, poor problem-solving skills, criminal associates, substance abuse, unemployment and poor family relationships. In the RNR model, antisocial personality traits may be conceptualised as criminogenic needs or as "responsivity factors" that interfere with treatment and reduce its effectiveness (Bonta and Andrews 2007, p.13).

In the Chromis model, which draws on RNR principles, personality traits are regarded as responsivity factors rather than as treatment "needs". Thus, the programme "does not aim to change personality traits but to work with these to reduce individuals' risk of violent offending" (Tew and Atkinson 2013, p.417). The underlying philosophy of this approach sees personality disordered offenders as affected by the same criminogenic risk factors as ordinary offenders but regards them as more challenging to engage in treatment. This indicates a movement towards assimilating personality disordered offenders into the mainstream and away from treating them as a case apart.

The aim of the creators of the Chromis programme was to adapt cognitive behavioural interventions to the characteristics of the DSPD group in order to increase their effectiveness. For example, the programme takes a "transparent" and "collaborative"

approach in order to engage a group that tends to be mistrustful. It also makes use of short session lengths and "novel and stimulating material" to keep the attention of participants who have a low tolerance for boredom (Tew and Atkinson 2013, p.420). The programme also harnesses personality characteristics that may assist the treatment process, such as a desire for choice and control (see further Tew and Atkinson 2013).

As mentioned previously, given the vast increase in numbers estimated to be eligible, the OPDP seems to be moving away from the requirement for a causal link between personality disorder and offending. The dilution of the entry criteria further blurs the distinction between severely personality disordered prisoners and other high risk and difficult to manage groups. Treatment programmes such as Chromis are compatible with this change and with the move towards a criminal justice pathway and away from a health model. The Chromis programme is only one of the interventions delivered at the treatment unit at HMP Frankland, however, which incorporates a range of other interventions, including some that have more in common with psychotherapy (see Burns *et al.* 2011). According to practitioners in interview, however, the Frankland programme remains more narrowly focused on reducing risk than its more holistic counterpart at HMP Whitemoor, described below.

(ii) The cognitive interpersonal model at HMP Whitemoor

The first DSPD prison unit at HMP Whitemoor is now a high security intervention unit on the OPDP. Its treatment programme is based on a cognitive interpersonal model that specifically targets trauma, a common aetiological factor in the development of personality disorders, and seeks to modify personality traits themselves (see further Saradjian, Murphy and McVey 2010). For example, one component of the programme encourages participants to connect with themselves as victims of their own traumatic backgrounds in order to develop empathy with their past and potential victims (Saradjian, Murphy and McVey 2010). The developers of the programme argue that such interventions can be expected to lead to more fundamental and long-lasting change than those focused more narrowly on behaviours (Saradjian, Murphy and McVey 2010).

As all participants in the programme undertake work relating to trauma, the approach is more holistic than risk-centred, and may also generate benefits to wellbeing as prisoners come to understand themselves better. According to one prison practitioner in interview, the programme at HMP Frankland is more focused on reducing risk, and explorations of

past trauma would only be undertaken if related to current risky behaviours. However, offending behaviour interventions are also undertaken at HMP Whitemoor in the later stages of treatment. Trauma-focused therapy therefore plays a role in stabilising prisoners so that they can then engage with behavioural interventions geared more explicitly towards reducing risk.

(c) Leaving room for welfare

In *The Culture of Control*, David Garland argues that "the practice of rehabilitation is increasingly inscribed in a framework of risk rather than a framework of welfare" and is "viewed as a means of managing risk, not a welfarist end in itself" (Garland 2001, p.176). Contemporary rehabilitation as described by Garland, is "a targeted intervention" aimed at "inculcating self-controls, reducing danger, enhancing the security of the public" (Garland 2001, p.176). Following on from this, Gwen Robinson argues that "late-modern" rehabilitative programmes "have secured legitimacy via a (re-) marketing campaign" that emphasises the "utilitarian" credentials of rehabilitation as a means of benefitting society and downplays its welfarist justifications (Robinson 2008, p.432. Emphasis in original). As the Victorian concept of "less eligibility" has been revived, "it is no longer offenders themselves who are seen as the main beneficiaries of rehabilitative interventions, but rather communities and potential victims" (Robinson 2008, p.432).

Treatments on the DSPD programme and the OPDP cannot be straightforwardly said to be aimed at protecting future victims rather than enhancing the welfare of the offender, however. Psychotherapeutic approaches, such as those employed on the OPDP, seek to help "patients understand and resolve their problems by increasing awareness of their inner world and its influence over relationships both past and present" (British Psychoanalytic Council 2016). These interventions aim for "deep seated change in personality and emotional development" by targeting the source of the patient's distress and enhancing his self-understanding (British Psychoanalytic Council 2016). CBT, on the other hand, focuses on managing symptoms and changing thought patterns, feelings and behaviours rather than targeting the source of the patient's problems (BABCP 2005). Nevertheless, it can also be used to enhance wellbeing, as demonstrated by the use of a variant, DBT, to reduce the frequency and severity of self-harming behaviour in individuals diagnosed with BPD (Linehan 1993). The subjective benefits and insights

into their own problems patients and prisoners reported having gained from the assessment and treatment processes (Tyrer *et al.* 2007; Burns *et al.* 2011) reflect the fact that behavioural and psychotherapeutic interventions can be employed to enhance wellbeing as well as to reduce the risk of violent or sexual offending.

For Robinson, "the disjunction of rehabilitation from welfarism is quite clearly evident in the new distinction between 'criminogenic' and 'non-criminogenic' offender needs, which essentially de-legitimates attention to problems or needs which cannot be shown to be directly linked with the individual's propensity to re-offend" (Robinson 2008, p.432). In Robinson's account, as rehabilitation has become separated from welfarism, the needs targeted for intervention reflect recidivism risk rather than traditional social work concerns as offenders' needs and the concept of rehabilitation are "'re-inscribed' in a risk management regime" (Robinson 1999, p.429). The place of more holistic treatments for personality disorder on the DSPD programme and the OPDP appears to contradict these trends, however, and suggests that the approach taken towards personality disordered offenders is welfarist as well as "utilitarian".

Holistic therapeutic interventions are "utilitarian" in the sense that they help to stabilise a disruptive group of patients and prisoners so that they can engage with more targeted offending behaviour programmes. They are also intended to improve the management of prisoners and patients and to reduce the costs associated with mental health crises, violence and self-harm. The DSPD offender presents a myriad of other risks in addition to risks to the public. In particular, the DSPD group posed risks to themselves, to staff and other prisoners and patients, and ultimately to the integrity and functioning of the institutions that housed them. These risks were also targeted by the DSPD proposals and the DSPD programme.

For Kelly Hannah-Moffat, the focus on "criminogenic needs" in Canadian risk/need offender behaviour programming "leaves intact the presumption that crime is the outcome of poor choices or decisions, and not the outcome of structural inequalities or pathology" (Hannah-Moffat 2005, p.41-2). The psychotherapeutic trauma-focused programme at HMP Whitemoor targets sources of distress that include histories of neglect and abuse common to personality disordered offenders (Saradjian, Murphy and McVey 2010). Arguably, this brings the social or "structural" causes of crime back into the equation.

The enduring relevance of more holistic interventions on the OPDP may be related to the background of forensic psychologists as mental health professionals. Despite the "instrumental" language of official government policy on rehabilitation, empirical studies of criminal justice practices demonstrate that the shift towards risk has been inconsistently implemented on the ground. Criminal justice workers have responded with forms of resistance and adaptation to current trends and there is evidence of a continuing commitment to welfarism in professions influenced by social work, such as probation (Robinson 1999; 2002; McNeill *et al.* 2009). The stated aim of reducing health inequalities on the OPDP also points in a welfarist direction, and interventions aim to stabilise offenders so that they can engage in more offending-focused rehabilitative work. Thus, there are similarities with the "penal welfare" era described by Garland (1985; 2001) in which both instrumental and welfarist arguments were put forward to justify interventions with offenders in the name of cutting crime or enhancing individual prospects.

6. Conclusion

It has been argued in this chapter that while the stated aims of the OPDP appear to be the same as those motivating the DSPD programme, improving wellbeing seems to take second place to the goal of protecting the public in policy plans. This indicates that the DSPD programme has been co-opted by a criminal justice system geared towards protecting the public from crime and monitoring and managing the risks posed by offenders rather than meeting their mental health needs. There are also indications of a movement away from treating the DSPD group as a case apart and towards assimilating them into the mainstream prison population. This position is congruent with treatment approaches on the OPDP that do not see personality disorder as causally linked to offending but rather as a hindrance to the engagement of certain offenders in mainstream behavioural interventions. On the other hand, these trends could be construed as the beginning of a movement towards interpreting the behaviour of all high risk and disruptive prisoners through the lens of personality disorder and the medicalization of offending.

Nevertheless, the OPDP continues to accommodate more holistic treatment approaches that target the causes of personality disorder and welfarist interventions retain a place on

the OPDP. However, the focus of the new pathway on high risk offenders and on those who are least likely to be motivated to engage with treatment indicates that the goal of reducing health inequalities is pursued inconsistently by the OPDP. Preventive detention on the grounds of risk to others also presents particular threats to the rights and interests of personality disordered offenders that may not be adequately addressed by the provision of rehabilitative treatments in prisons. This issue will be considered in greater depth in the second half of this thesis, beginning with the next chapter.

Part II: Dangerous Offenders with Severe Personality Disorders and the Legal Framework

Chapter 5: Dangerous Personality Disordered Offenders in the Criminal Justice System

1. Introduction

In the first part of this thesis, the origins of the DSPD proposals and the subsequent development of the DSPD programme and the OPDP were explored. It emerged from the analysis presented that the DSPD proposals and the subsequent DSPD programme were intended to strike a compromise between the concerns of the Department of Health to improve the management of a difficult patient group and the aim of the Home Office to protect the public from dangerous offenders. It was also argued that there was a degree of overlap between the interests of the two departments and that the proposals were interdepartmental. The offer of rehabilitation and a route towards release in exchange for preventive detention was also intended to strike a "balance" between the purported right of the public to be protected and the civil liberties of the offender. This translated across to the pilot DSPD programme, which was intended to improve public protection and mental health outcomes. The controversial DSPD proposals were never implemented in full and little attention has since been paid to the complex web of legal provisions that currently govern the DSPD group. The second part of this thesis, beginning with this chapter, aims to fill that gap by examining the legal framework governing the detention and treatment of offenders in the DSPD category and those subject to the OPDP in the criminal justice and mental health systems.

Like in the plans for the OPDP, the legal framework has shifted towards managing the DSPD group in the criminal justice system and away from the health system. Furthermore, the increasing use of indeterminate and lengthy determinate sentences, supervision requirements and civil preventive orders with dangerous offenders points towards a revival of liability for defective criminal character. In this process, liberal criminal law principles have been side-lined and the protection of the public takes priority over the individual rights of offenders. Concomitant with this trend is an increased reliance on both risk monitoring and rehabilitation as a means of preventing reoffending. In this context, selection for the DSPD programme or OPDP can operate to hold back personality disordered offenders who may find it particularly difficult to prove their suitability for release.

The analysis of the European Court of Human Rights (ECtHR) jurisprudence on whole life tariffs, IPP sentences and preventive detention presented in this chapter reveals that the Court also tries to strike a "balance" between the competing rights of the offender and those of the public. It will be argued, however, that in both the domestic and European legal regimes, the public's "right to security" (Lazarus 2007; 2012; Ramsay 2012a; 2012b; 2012c) takes precedence over the offender's "right to rehabilitation" (Van Zyl Smit *et al.* 2014). Rather than having a "right" to rehabilitation, therefore, offenders who are labelled as dangerous have a "duty" to engage in rehabilitation. This gives the "balance" struck between competing rights a progressive appearance that conceals its fundamental coerciveness. This coercion may jeopardise the effectiveness of treatment efforts with personality disordered individuals.

2. The DSPD Proposals: Legal Gaps and Options for Policy Development

The 1999 consultation paper *Managing Dangerous People with Severe Personality Disorder* (Home Office and Department of Health 1999) outlined gaps in the legal framework governing those in the DSPD group. In essence, the majority of those in the DSPD group were expected to have been "convicted of crimes that potentially carry life sentences, but many [had] not receive[d] life sentences". As a result, some presented "a grave danger when […] released from prison at the end of a determinate sentence" (Home Office and Department of Health 1999, p. 7). Furthermore, the "treatability" clause in the MHA 1983 was presented as a barrier to the detention of this group in secure hospitals.

In formulating the DSPD proposals, the Department of Health and Home Office were concerned to ensure that any proposals to change the law would be compliant with the ECHR. The aim was "to get the right balance between the human rights of individuals and the right of the public to be protected from these very dangerous people" (Boateng and Sharland 1999, p.7). Another expression of this "balance" was "between the civil liberties of those who may be detained and those who might otherwise become victims" (Boateng and Sharland 1999, p.5). The terms of the proposed bargain meant that, in exchange for their detention to protect the public, dangerous offenders with personality disorder would be offered tailored treatments aimed both at alleviating their personal distress and reducing the risks they posed so that they could eventually be released.

Tellingly, however, where such interventions were found not to reduce the risks posed by the DSPD group, there would be "no alternative but to continue to detain them indefinitely if the public is to be properly protected" (Home Office and Department of Health 1999, p.9). Two options for policy development were put forward: Option A and Option B.

(a) Option A

Under Option A, DSPD offenders were to be given prison sentences rather than hospital disposals at sentencing and the detention and supervision of those not subject to a prison or community sentence would be pursued through mental health law. Rather than taking up the recommendation of the Butler (1975) and Fallon (1999) reports to introduce a reviewable sentence for psychopathic offenders, Option A proposed to extend the discretionary life sentence to a broader range of crimes and to encourage the judiciary to make greater use of this sentence with the DSPD group (Home Office and Department of Health 1999, p.21). In contrast to the eventual IPP sentence, there were no proposals in Option A to fetter the discretion of judges or to force them to hand down indeterminate sentences on the grounds of risk. Option A also contained proposals to establish centrally funded and commissioned specialist DSPD services within the prison and hospital systems. This would have fallen short of establishing a "whole system" for DSPD offenders, however, and any new services would risk becoming subject to the internal pressures and cultures of the institutions that housed them. Option B presented a more appealing solution for the government and was initially favoured by politicians and policymakers.

(b) Option B: The Third Service

Under Option B, a new service separate from the prison and health services would be established for the DSPD group, and individuals could be detained there on the basis of a "DSPD direction" (Home Office and Department of Health 1999, p.24). DSPD directions could be attached to any prison sentence, except the mandatory life sentence for murder, or made in civil proceedings "on the basis of evidence that the offender was suffering from a severe personality disorder and as a consequence of the disorder presented a serious risk to the public" (Home Office and Department of Health 1999, p.24). The effect of a DSPD order would be to detain the offender in a specialist facility "until such time as [he was] no longer considered to present a serious risk on the

grounds of [his] disorder" (Home Office and Department of Health 1999, p.24). Those released from the third service would also be monitored in the community and subject to recall. The order would be "subject to appeal and periodic review" but the details of this procedure had yet to be developed (Home Office and Department of Health 1999, p.24).

As discussed in Chapters 2 and 3, the proposals were met with strong opposition from lawyers and mental health practitioners and neither option came to fruition. Instead, a pilot service for the DSPD group was established in prisons, hospitals and in the community to develop and test potential treatment and management techniques for personality disorder within existing legal frameworks. Nevertheless, as will be argued in this chapter, control has incrementally been extended over a much larger group than envisaged under the DSPD proposals through developments in criminal and civil law that have taken place since 1999. Like the OPDP, these developments indicate that the dangerous personality disordered offender is increasingly coming within the purview of the criminal justice system. Legal developments also reflect a similar "balance" is being struck between the rights and interests of personality disordered offenders and the public, but the basis for this balance may be questioned as it is not clear that the provision of rehabilitation is an adequate brake on punishment.

3. Legal Developments Following the 1999 Green Paper

The DSPD group has come to be governed by a complex web of sentencing provisions and civil orders with criminal penalties for breach. These changes have largely been achieved within the framework of the existing law. It will be argued that this seems to run contrary to the "counter-law" thesis of Bill Hebenton and Toby Seddon, who argue that the DSPD proposals represented "the deployment of law against law in order to erode, eliminate or circumvent laws or legal procedures that are perceived to get in the way of the pre-emption of harms" (Hebenton and Seddon 2009, p.346). This claim will be examined further in this section.

(a) Indeterminate sentences

Recent years have seen an increase in the number of prisoners serving life or IPP sentences. The jurisdiction of England and Wales now has the highest number of

prisoners serving indeterminate sentences in Europe and the total is more than three times higher than the figures for France, Germany and Italy combined (Prison Reform Trust 2015, p.3). Indeterminate sentences account for 18% of the sentenced prison population, up from 9% in 1993 (Prison Reform Trust 2015, p.2). Tariff length has also increased over time, and a growing number of prisoners are now subject to a "whole life tariff". On 31 March 2016, there were 54 prisoners serving whole life tariffs, 12 more than on the same date in 2013 (Ministry of Justice 2016b, Table 1.9; Ministry of Justice 2013b, Table 1.4). The expanding use of these sentences seems to have negated the need for reviewable sentences for the DSPD group, as discussed below.

(i) Discretionary life sentences

As noted above, Option A proposed expanding the use of the discretionary life sentence in order to tackle the problem of dangerous offenders released from determinate prison sentences. This is not surprising in light of the history of this sentence, which evolved "as a measure of preventive detention for mentally unstable and dangerous offenders as a result of judicial innovation from the 1950s onwards" (Cullen and Newell 1999, p. 109). According to the MEMOS study, the majority (82%) of those in the prison DSPD units were serving indeterminate sentences, and the remaining 17% were serving determinate sentences (Trebilcock and Weaver 2010a, p.30–1). Most of the indeterminate sentenced group were serving life sentences, with just three inmates on IPP sentences (Trebilcock and Weaver 2010a, p.30–1).

The history of the sentence reflects that it has long been used to manage the risks posed by dangerous or mentally unstable offenders similar to those in the DSPD group. An early authoritative statement of the circumstances in which such a sentence was warranted was given by the Court of Appeal in *R. v. Hodgson* (1967) 52 Cr App R113:

> (1) Where the offence or offences are in themselves grave enough to require a very long sentence; (2) where it appears from the nature of the offences or from the defendant's history that he is a person of unstable character likely to commit such offences in the future; and (3) where if the offences are committed the consequences to others may be specially injurious, as in the case of sexual offences or crimes of violence.

These criteria were further elaborated upon by the Court of Appeal in *R. v. Wilkinson* (1983) 5 Cr App R (S) 105, in which it stated that such sentences "must only be passed in the most exceptional circumstances" and should generally be reserved "for offenders who for one reason or another cannot be dealt with under the Mental Health Act, yet are in a mental state which makes them dangerous to the life or limb of the public" (*Wilkinson*, p.108-9).

Subsequently, the reach of the discretionary life sentence was extended beyond the mentally unstable offender to rational but dangerous individuals. In the case of *R. v. McNee, Gunn and Russell* [2008] 1 Cr App R (S) 108, the Court of Appeal accepted that evidence "suggesting irrationality, or instability of the personality" was not necessary in all cases. Indeed, where there was evidence that the offender "represented a continuing risk for the indefinite future […] the danger could be represented by a wholly rational individual" (*McNee*, para. 34). In the case of *R. v. Kehoe* [2009] 1 Cr. App. R. (S.) 9, the Court of Appeal reiterated, however, that discretionary life sentences should continue to "be reserved for those cases where the culpability of the offender is particularly high or the offence itself particularly grave" (*Kehoe*, para. 17).

The reference to "unstable character" in *Hodgson* indicates that the discretionary life sentence is a form of liability for defective criminal character, which dates back to Victorian times. Nicola Lacey defines character responsibility as "a pattern or practice of responsibility-attribution which is premised in whole or in part on an evaluation or estimation of the quality of the defendant's (manifested or assumed) disposition as distinct from his or her conduct" (2011, p.153). The discretionary life sentence also creates a form of quasi-criminal status based on criminal character, as the breach of licence conditions following release can result in recall to prison, even where no new crime has been committed (Lacey 2011).

(ii) IPP sentences[4]

The IPP sentence was introduced by s.225 of the CJA 2003 along with a number of other provisions for dangerous offenders and eroded the place of the discretionary life sentence as a risk-based sentence. Like a life sentence, the IPP sentence is a hybrid of a determinate punitive "tariff" and an indeterminate period of preventive detention which

[4] Parts of this section have been taken from O'Loughlin, A. (2014) "The Offender Personality Disorder Pathway: Expansion in the Face of Failure?", *Howard Journal of Criminal Justice* 53(2), 173 – 192.

begins after tariff expiry and lasts until the Parole Board decides that the prisoner's detention is no longer necessary for the protection of the public (Crime (Sentences) Act 1997, s.28). The IPP may also be conceptualised as a form of character liability based on a statutory presumption of dangerousness arising from a previous conviction for certain offences specified under Schedule 15 to the 2003 Act. Jessica Jacobson and Mike Hough assert that both the dangerousness provisions of the CJA 2003 and the DSPD programme were "manifestations of an emerging culture of risk aversion across the criminal justice system, mental health services and, indeed, wider society" (Jacobson and Hough 2010, p.5). As the authors point out, in the case of the IPP and the DSPD proposals, "the person's likely future behaviour, and not just the gravity of past behaviour, guides the choice of sentence" (Jacobson and Hough 2010, p.5).

By contrast to a life sentence, after 10 years of release on licence, an individual may apply to the Parole Board to have his IPP licence cancelled. This establishes somewhat of a hierarchy of seriousness between IPP and discretionary life sentences. Similarly to the discretionary life sentence, the rationale behind the IPP sentence was to prevent the premature release of offenders who were still thought to be dangerous at the end of a determinate prison sentence (Annison 2015). The reach of the IPP extended well beyond the group to whom the discretionary life sentence was intended to apply after *Wilkinson*, however, and the provisions of the CJA 2003 significantly curbed judicial discretion.

The IPP sentence was initially criticised for its harshness and the broad scope of the specified offences under Schedule 15 to CJA 2003, which triggered a presumption of dangerousness (Prison Reform Trust 2007; Harrison 2010). The original provisions were highly prescriptive, preventing judges from exercising their discretion in cases in which all the conditions for imposing an IPP sentence were met, even where the circumstances of the case did not otherwise warrant an indeterminate sentence. The impact of the IPP on the prison system was underestimated by the Home Office, which predicted that the prison population would increase by just 3,500 following its introduction and that the effect would level off by 2012 (de Silva *et al.* 2006, p.8). In the three years following their introduction, the number of prisoners on IPP sentences increased more than fivefold from 1,100 in 2006 to 5,600 in 2009 (HC Deb, 16 January 2008, col. 1337W; HL Deb, 28 October 2009, col. 1254). By June 2012, numbers had reached 6,020 (Ministry of Justice 2012a, p.7). In the same period, the prison population

increased by more than 8,500, from 78,127 in 2006 to 86,634 in 2012 (Ministry of Justice 2015c, Table A1.2).

The prison system was ill-prepared to deal with the influx of IPP prisoners, resulting in overcrowding and stretched resources. The sentence was challenged in the domestic courts and in the ECtHR (see below) and it was eventually abolished by the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 introduced by the Coalition government. As abolition did not have retrospective effect, however, large numbers of IPP prisoners remain incarcerated. As of 31 March 2016, 4,133 prisoners are still serving IPP sentences and more than three quarters (3,330) have passed their tariff expiry dates (Ministry of Justice 2016b, Table 1.9). Many of those still detained are serving sentences with short punitive tariffs: 693 continue to be detained following the expiry of tariffs of less than two years and 1,787 have passed tariffs of between two and four years (Ministry of Justice 2016b, Table 1.9). In light of the decision of the ECtHR in *James*, discussed further below, all post-tariff IPP prisoners may be in a position to seek release, damages or both (Ashworth and Zedner 2014, p. 160).

Prisoners sentenced to IPP are disproportionately affected by mental health problems when compared to both life sentenced prisoners and the general prison population (Sainsbury Centre 2008, p.39). This disparity prompted Max Rutherford (2009) to dub the IPP sentence an example of the "reverse diversion" of mentally disordered offenders from the mental health system into the criminal justice system. In a search of OASys data, 59% of IPP prisoners were found to require a clinical assessment for DSPD programme entry, compared to 34% of life-sentenced prisoners and 29% of the general prison population (Rutherford 2009, p.S53). In 2007, just three of the MEMOS sample of 174 patients and prisoners were serving IPP (Trebilcock and Weaver 2010a, p. 31), but by 31st December 2011, numbers had increased to just over 13% (HC Deb, 17 September 2012, col. 473W).

Prisoners on IPP sentences are also disproportionately likely to be selected for the OPDP. In June 2012, it was estimated that 21% of the male IPP prison population met the screening criteria for the OPDP (Skett and Goode 2015). This was compared to 10% of male prisoners on life and determinate sentences of more than one year and 11% of those on determinate sentences of less than one year. The estimate for recalled male prisoners was higher, at 27%. The numbers are even higher for the female prison

population, bearing in mind that the OPDP criteria for women are much broader than for men. 80% of the female prison population serving IPP sentences were estimated to meet the screening criteria, compared to 48% of those serving determinate sentences of less than a year, 46% of those serving determinate sentences of less than a year, 55% of those serving life sentences, and 74% of the female recall population (Skett and Goode 2015).

(b) Dangerous offenders under the Coalition

(i) Extending detention

Following its abolition by LASPO 2012, the IPP has been replaced with the life sentence for a second serious offence (also known as the "two strikes life sentence"). This sentence applies to offenders with a previous conviction for a serious violent or sexual offence listed in Schedule 15B to the CJA 2003 who are being sentenced for a second such offence. The legislation contains a saving provision in s.224A that allows the judge to decline to pass such a sentence if to do so would be unjust. Thus, the provisions portray the message of "toughness" desired by the government, while not fettering judicial discretion entirely and repeating the mistakes of the IPP sentence. According to Martin Wasik, the use of the two strikes sentence may be expected to be rare due to the numerous conditions contained in s.224A. He further argues that many offenders who would qualify for this sentence would most likely have been subject to a discretionary life sentence in any case and therefore the new provisions may not have a significant impact (Wasik 2014, p. 478).

LASPO 2012 also abolished the extended sentence for public protection (EPP) introduced by s.227 CJA 2003. The aim of this sentence was to allow judges to pass a determinate sentence with an extra measure of protection for the public where the maximum penalty for an offence was less than 10 years (Home Office 2006, p. 39). It is composed of a determinate custodial term plus an extended licence period of up to 5 years for a specified violent offence and 8 years for a specified sexual offence and, together, the custodial and licence periods cannot exceed the maximum penalty for the offence (s.227(4) and (5), former CJA 2003). The EPP has been replaced with the new extended determinate sentence (EDS). The same maximum licence periods are available under an EDS as under an EPP but prisoners serving an EDS will not be released until

they have served two-thirds of their custodial term, rather than at the half-way point as under an EPP.

The recent Criminal Justice and Courts Act (CJCA) 2015 ended automatic release for those sentenced to an EDS on or after 13 April 2015 at the two-thirds point. These prisoners will instead have to apply to the Parole Board for early release. Recent changes have also extended licence supervision over determinate sentenced prisoners. Under the original CJA 2003, prisoners serving determinate sentences of less than 12 months were released at the half-way point unconditionally (CJA 2003, s.243A). The Offender Rehabilitation Act (ORA) 2014 extended licence conditions and parole supervision to prisoners sentenced to more than one day but less than two years imprisonment in respect of crimes committed on or before 1 February 2015. Those serving 12 months or more continue to be released subject to a conditional licence which lasts until the end of the sentence (CJA 2003, s.244). While on licence, offenders are subject to probation supervision and must comply with conditions or else be recalled to prison. This extends control over an even greater number of prisoners than ever before, and may also be expected to contribute to further prison overcrowding as prisoners caught up in the system struggle to prove their suitability for release. The EDS may therefore become the IPP of the future.

According to Leon McRae, "SPD [severely personality disordered] offenders will ally with medical practitioners in the pursuit of pro-social behaviour (rehabilitation) if it serves ulterior gain" (McRae 2015, p.8; see also McRae 2013). For McRae, offenders on IPP sentences therefore had an incentive to engage with treatment as this could be expected to expedite their release by the Parole Board. In his view, the "absence of coercion" resulting from the removal of the IPP sentence and its replacement with the EDS "may undermine efforts to identify and encourage SPD offenders to take responsibility for their criminogenic risk" (McRae 2015, p.8). This is because offenders serving an EDS of less than 10 years will be "unlikely to be motivated to seek, and engage in, treatment" because they will benefit from automatic release in any case (McRae 2015, p.13).

McRae argues that this oversight is due to the Coalition government's "failure […] to identify the link between indeterminate sentences (punitiveness) and treatment engagement (*qua* rehabilitation)". In his view, "external motivation (legal coercion) is

an important pre-requisite to exposing the patient to what might be an effective 'treatment dose' over time" (McRae 2013, p.66). According to McRae, while a patient may begin by engaging in treatment in the hope of progressing towards release, "upon reaching a notional 'treatment dose'", this may give way to "pro-social behaviour" that is "self-regulating" (McRae 2013, p.67). The applicability of McRae's findings to the DSPD context may be questioned, however. As noted previously, the IMPALOX (Tyrer *et al.* 2007), IDEA (Burns *et al.* 2011) and MEMOS (Trebilcock and Weaver 2010a; 2010b) studies indicate that patients and prisoners participated in the DSPD programme for a range of reasons. Some pursued treatment in the hope that this would expedite their release from prison while others sought to better understand themselves and their reasons for offending and to enhance their quality of life.

Furthermore, McRae underplays the negative effects coercion can have on treatment engagement in the personality disorder group. The clearest example of this was the disruption to the work of the hospital units caused by the presence of a group of disgruntled patients who had been transferred to hospital late in sentence. Even the more subtle forms of legal coercion referred to by McRae may undermine treatment efforts. The effectiveness of the treatments deployed on the DSPD programme and its successor depends on the patient's willingness to engage and his motivation to change. McRae acknowledges the warning contained in the NICE guidelines on ASPD (NCCMH *et al.* 2010), that "it is very unlikely that all antisocial patients can be *coerced* into pro-social thinking or behaviour" (McRae 2013, p. 51). There is also a substantial literature that contends that punishment and rehabilitation are not compatible with each other, and that tying prisoners' release dates to their successful rehabilitation jeopardises the success of rehabilitation and risks disproportionate punishment (Hudson 1987; Rotman 1990; Lewis 2005; Moore and Hannah-Moffat 2005). In the final chapter of this thesis, the relationship between coercion, punishment and rehabilitation will be explored further. It will be argued that tying release to progress in rehabilitation may in fact undermine efforts to treat personality disordered offenders and is likely to lead to greater use of preventive detention and punishment. In addition, the use of psychological interventions geared towards reducing offending behaviour in the prison setting may expose prisoners to greater harsh treatment and increase their subjective experience of punishment.

The removal of the IPP sentence has partially re-opened the gap identified by the 1999 consultation paper in cases in which the two strikes life sentence does not apply but the

EDS is not sufficient to protect the public from a dangerous offender. In the recent case of *R. v. Saunders* [2014] 1 Cr. App. R. (S.) 45, the CA recommended that judges pass a discretionary life sentence where the EDS will not ensure sufficient protection for the public. The CA in *Saunders* also removed the "denunciatory value" requirement established in *Wilkinson*, stating that it was no longer necessary to distinguish between serious cases deserving of the public abhorrence conveyed by a discretionary life sentence and lesser cases attracting an IPP sentence. The use of discretionary life sentences may be expected to increase following this guidance. Nevertheless, the Court in *Saunders* went on to emphasise that the discretionary life sentence should remain a last resort.

It remains to be seen, therefore, whether the discretionary life sentence will be applied to offenders whose records show a pattern of growing seriousness but where the current offence is not of the particular gravity required by *Wilkinson* and *Kehoe*. On one hand, judges may now be more conscious of the risks presented by offenders and may be more inclined to use the discretionary life sentence in a climate of risk aversion. On the other hand, having seen the problems the IPP sentence created in the prison system and the numbers that are still currently serving such sentences, they may be more inclined to pass a long determinate sentence. The insistence in *Saunders* that the discretionary life sentence continue to be a measure of last resort also tends in this direction.

(ii) Extending supervision

Recent years have also seen the expansion of civil orders with criminal penalties for breach, which may also be described as a form of status or character liability aimed at controlling dangerous offenders. Option A of the DSPD proposals envisaged the creation of new civil law powers of supervision over individuals in the DSPD group upon their release from hospital. The introduction of civil orders with criminal consequences for breach was also a feature of the Labour government's reshaping of criminal justice. Coupled with the increasing use of indeterminate sentences and the extension of release on licence to determinate sentenced prisoners, the coercive reach of the criminal and civil law has been considerably extended since 1999.

The Sexual Offences Prevention Order (SOPO) was introduced by s.104 of the Sexual Offences Act 2003 and the Violent Offender Order (VOO) was introduced by s.98 of the Criminal Justice and Immigration Act 2008. A SOPO may be handed down to

offenders who have been convicted or cautioned of particular sexual offences. A VOO, on the other hand, is only available where the individual has been convicted of a particular violent offence. The purpose of both orders is to protect potential victims from "serious" harm at the hands of the offender. Convicted sexual offenders are made subject to notification requirements irrespective of whether or not a SOPO has been made, whereas notification requirements only apply to violent offenders subject to a VOO. It may therefore be seen that sexual offenders are subject to a much more restrictive regime than violent offenders, reflecting a public and policy concern for preventing sexual offending. The penalty for breach of a SOPO or VOO or notification requirements is up to 5 years' imprisonment upon conviction. Such orders may be used in respect of prisoners released at the end of a determinate prison sentence, or in respect of offenders who have been found not guilty by reason of insanity or unfit to plead but to have done the act in question. Thus, an individual may find himself in court again for breach of an order and again pleading unfitness or insanity, in a cycle that could prove never-ending.

The recent changes to sentencing demonstrate that recent Conservative-led governments have pursued the agenda of ensuring that greater numbers of offenders spend increasingly longer periods in prison and under supervision in the community. Thus, the IPP sentence has been replaced with ever-lengthening custodial and licence periods that attempt to close the gap with life sentences. Together, these developments indicate that the preventive arm of the criminal justice system is growing to close the gap with the mental health system in the case of personality disordered offenders. Nevertheless, where prison sentences end, offenders with personality disorder may still be made subject to detention in hospital under the MHA 1983, as discussed in the next chapter.

(c) Counter-law?

Bill Hebenton and Toby Seddon argue that the DSPD proposals were form of "counter-law" as described by Richard V. Ericson (2007), who drew on the use of the term by Michel Foucault (1977). "Counter-law I", in Ericson's terms, "takes the form of laws against law" as "new laws are enacted and new uses of existing law are invented to erode or eliminate traditional principles, standards and procedures of criminal law that get in the way of pre-empting imagined sources of harm" (Ericson 2007, p. 24). "Counter-law II" on the other hand, "takes the form of surveillant assemblages". Here,

"new surveillance infrastructures are developed and new uses of existing surveillance networks are extended that also erode or eliminate traditional standards, principles and procedures of criminal law that get in the way of pre-empting imagined sources of harm" (Ericson 2007, p. 24). According to Hebenton and Seddon, the proposal to create a DSPD direction, that would allow individuals to be detained regardless of whether or not they had been convicted of any crime, deployed the first form of counter-law "with the primary aim of getting around the legal barriers to the use of coercive institutional confinement (in both prisons and secure psychiatric facilities) as a preventive strategy" (Hebenton and Seddon 2009, p.347). In the event, however, the plans for civil detention did not materialise. Instead, the dangerous offender provisions in the CJA 2003 came to close the gap identified in the DSPD proposals and mental health law was altered, as considered in the next chapter.

The discretionary life sentence and the IPP sentence may be described as a form of "counter-law" as they bring a measure of administrative discretion into the quantum of punishment decided by the court at sentencing. The role of "surveillance" in this context is to monitor the risks posed by the individual and allow for the continuation of his detention where those risks remain. The individual is also monitored in the community and his detention may be resumed if he fails to adhere to the conditions governing his release. Thus, surveillance appears to operate on the "underside of the law" and "supports, reinforces, multiplies the asymmetry of power" between the individual offender and the state (Foucault 1977, p.22-23, quoted by Ericson 2007, p.30).

However, it might be questioned whether it also serves to "[undermine] the limits that are traced around the law" (Foucault 1977). This is because the law itself leaves room for "counter-law" by allowing for preventive sentencing and preventive detention in hospital on the grounds of risk to the public. The "limits" traced around the law in Ericson's account are the limits of liberal criminal law with its attendant "traditional" "high standards of due process, evidence, proof and culpability" (Ericson 2007, p. 24). This is not the only form taken by criminal law, however, as forms of character liability like the discretionary life sentence compete with the model of subjective capacity-based responsibility that has come to dominate the criminal law and criminal law theory (Lacey 2011).

Both the SOPO and VOO create a form of status liability based on offending and a risk of serious harm to the public. The effect is to extend preventive control over sexual and violent offenders in the community on the grounds of a future, and therefore uncertain, risk of serious harm. For Lacey "status offences or semi-status offences […] as well as regular recreations of 'dangerousness' categories, show that the impulse to organize responsibility-attribution along status lines is a pervasive one in the history of criminal law" (Lacey 2011, p.160). She argues that the creation of "a quasi-criminal status" or "prima facie judgment of criminal propensity" which "sits unhappily with the idea of punishment as commensurate to crime" (Lacey 2011, p.168-169).

Status criminalisation is indeed at odds with the "modern" criminal law principles that "defendants are punished not for who or what they are, but simply for what they have done" and that "criminal responsibility pertains only to voluntary acts" (Lacey 2011, p.160-1). Lacey further argues, however, that forms of liability for criminal character should not be dismissed as anomalies but rather reflect fundamental disagreements on what the purpose of the criminal law should be: to punish culpable acts (retributivism) or to reduce or prevent crime (consequentialism) (Lacey 1987).

The counter-law thesis is, however, useful in highlighting how far control can be extended through administrative means and the potential for measures designated as "preventive" to also be punitive. The key aim of the discretionary life and IPP sentences is to manage risk rather than to punish. However, in the execution of these sentences, the consequentialist and retributivist aims of the law are confused, as both the punitive and preventive periods are served in the same prison environment. Thus, once his punitive tariff elapses, the prisoner continues to be punished by being deprived of his liberty in prison until he can show a reduction in risk. In this sense, the prisoner is punished for "who" or "what" he is (a dangerous person) in addition to what he has done.

The reliance on rehabilitation as a limit on disproportionate punishment in the jurisprudence of the ECtHR discussed further below also seems to confuse retributivism and consequentialism, and the risk aversion underlying the Court's approach undermines its commitment to rehabilitation as a "right" of those subject to detention on the grounds of risk (Van Zyl Smit *et al.* 2014). Selection for the DSPD programme or OPDP can also operate to hold prisoners back as the completion of these programmes

has become an administrative requirement for release despite continuing doubts surrounding their effectiveness in reducing risk.

4. The Journey to Release

(a) Participation as an administrative requirement

A large proportion of prisoners on the OPDP may be expected to be serving indeterminate sentences or extended determinate sentences and their release will be at the discretion of the Parole Board. The Parole Board has the power to direct the release of prisoners on licence where it "is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined" (Crime (Sentences) Act 1997, s28(6)(b)). It can also recommend that a prisoner be transferred to an open prison (Category D) but it cannot otherwise make recommendations regarding his security categorisation. More pertinent for high security prisoners are the recommendations of the Category A Review Teams (CART) and the decisions of the Deputy Director of Custody High Security (DDC-HS) in NOMS who is responsible for the re-categorisation of Category A prisoners. In this section, the impact of selection for the DSPD programme or OPDP for prisoner progress will be examined.

Julie Trebilcock and Tim Weaver (2010a; 2012a) studied the influence of DSPD status on Parole Board decision-making as part of the MEMOS study. Upon entry to the DSPD programme, the majority (63%) of the MEMOS prison sample were in Category B, 34% were in Category A, and 2% in Category C (Trebilcock and Weaver 2010a, p.32). The majority (77%) had been transferred from high security prisons, 20% had come from Category B prisons, and the remainder from Category C prisons (Trebilcock and Weaver 2010a, p.32). As DSPD prisoners were generally high security prisoners serving long sentences they had to "undergo a journey through different levels of security to enable their risk to be tested at different stages of their sentence" (Trebilcock and Weaver 2010a, p.45). Prisoners' "journeys" are influenced by selection for treatment programmes such as the DSPD programme and the OPDP, which serve to impede or facilitate their progress through the system.

As was the case under the DSPD programme, admission to the OPDP is an administrative decision taken by the prison or hospital authorities. As mentioned in the

previous chapter, practitioners in interview asserted that if a prisoner was assessed to be suitable for the DSPD programme, it would remain on his sentence plan, and he would not make progress until he completed treatment. This is also reflected in the case law on categorisation decisions. In the case of *R. (S) v. Secretary of State for Justice* [2009] EWHC 2168 (Admin), the DDC-HS decided not to downgrade a prisoner to Category B on the grounds, *inter alia*, that he was "not satisfied that he [could] make the judgment on risk which he is required to make without the whole six years of the Fens Unit [DSPD] programme being completed". The decision was upheld by the High Court on judicial review. Similarly, in *R. (Guntrip) v. Secretary of State for Justice* [2010] EWHC 3188, the applicant's refusal to engage in offending behaviour work or with treatment in a DSPD unit or TC as recommended by the Parole Board and Secretary of State meant that his Offender Supervisor could not recommend any further progression.

In *R. (Falconer) v. Secretary of State for Justice* [2009] EWHC 2341 (Admin), the CART declined to recommend the applicant for downgrading to Category B on the grounds that, although his behaviour in prison had been good and he had participated in some programmes, he had not addressed his violent offending. His participation in the five-year DSPD programme, or an alternative programme if he did not meet the DSPD criteria, would be required to demonstrate a reduction in risk. The High Court held that it was "in the prisoner's own interests that he undertakes the work required by the DSPD programme, onerous as it is, so as to establish the grounds for a finding that the risk he presents is substantially reduced" (*Falconer*, p.7). In the absence of participation in the programme he was unlikely to make further progress towards release.

Participation in the DSPD programme has thus become an administrative requirement for prisoners identified as suitable for it to demonstrate their suitability for release to the Parole Board. This is despite the doubts expressed by Parole Board members in the MEMOS study on whether treatment for personality disorder is effective in reducing risk (Trebilcock and Weaver 2010a; 2012a). As Kelly Hannah-Moffat (2015) argues, unmet treatment needs are easily elided with risk in the risk/need paradigm. Thus, suitability for the DSPD programme or the OPDP may have the effect of placing a further hurdle in front of prisoners serving indeterminate sentences on their journey towards release.

(b) Evaluating risk

More recent information is now available on prisoners who have completed the DSPD programme. By January 2014, 25 prisoners had completed treatment in HMP Frankland's Westgate unit, and reductions in actuarial risk scores were observed in all but 5 completers (Bennett 2014, p.21). However, only 8 treatment completers were re-categorised to a lower security category and none of these were originally in Category A. The Category A completers were, however, able to make progressive moves to mainstream prisons or PIPEs (Bennett 2014, p.21). The numbers completing the treatment programme seem rather low considering the Westgate unit opened in March 2004 and there were 75 prisoners in the unit by 2007 (Trebilcock and Weaver 2010b, p.23). While the data indicates that some reductions in risk have been achieved, onward progression continues to be slow and very few prisoners experienced a change in security category after completing the programme.

Practitioners in the DSPD unit at HMP Whitemoor reported in 2010 that five of the nine Category A prisoners in the first cohort of 18 men to finish treatment at the unit had been re-categorised and one man had been safely discharged into the community (Saradjian, Murphy and Casey 2010). It seems that the remainder were transferred to Category B prisons, but their initial security categorisation is unclear. Reductions in VRS scores for all but two men on the programme were also reported. Again, however, these numbers appear small when we consider that the HMP Whitemoor unit opened in 2002 and there were 64 prisoners in the unit by 2007 (Trebilcock and Weaver 2010b, p.23). Thus, treatment completion rates at the units appear to be low, and those who have completed treatment are not necessarily assessed to be suitable for a reduction in security category.

As elaborated further below, the presumption of risk attaching to offenders in the DSPD/OPDP group also gives rise to a duty to prove, through participation in rehabilitation, that they no longer pose a threat to vulnerable members of the public. In a climate of risk-aversion that prioritises the protection of the public over the rehabilitation of offenders it may prove difficult for offenders selected for the OPDP to prove their suitability for release from indeterminate sentences. This is particularly the case in the face of a continuing lack of evidence for effective treatments for antisocial forms of personality disorder. The effect of this may be to subject this group to increasing punishment, as they are given a label associated with a high risk of reoffending and resistance to treatment without an effective means for removing it.

5. Preventive Detention in Human Rights Law

It has been argued in the first part of this chapter that the criminal law has gradually extended its coercive reach over a larger range of dangerous offenders than the original DSPD group. This reflects the revival of liability for criminal character and results in the punishment of offenders for who they are rather than what they have done. In this context, the revival of rehabilitation as an aim of the criminal justice system is not surprising, as forms of character liability and the Victorian notion of "reform" through punishment have historically been intertwined (Lacey 2001a; 2011; Garland 1985; see further Chapter 7). As will be seen through the discussion of ECtHR case law presented in this section, the legitimacy of preventive detention on the grounds of dangerousness is dependent on the provision of rehabilitation and a route towards release. However, the ECtHR also recognises a "right" of the public to be protected from dangerous offenders that has the potential to conflict with the offender's "right" to rehabilitation and reintegration into society. In the final analysis, as in the DSPD proposals, the right of the public to protection trumps the offender's right to rehabilitation. This raises the question of whether the current system is intended to achieve a "balance" between competing rights or is simply a means of pursuing the protection of the public.

(a) Preventive detention and liberty

Originally, the indeterminate character of the discretionary life sentence discussed previously was intended to guard not only against the release of dangerous prisoners but also against the disproportionate punishment that might be imposed by a lengthy determinate sentence as the possibility of early release remained open (Appleton 2010, p.13). This argument was accepted by the ECtHR in *Weeks v. UK*. In that case, the ECtHR approved a discretionary life sentence for armed robbery that had been handed down to the applicant when he was aged just 17. During the course of the offence, the applicant had threatened the owner of a pet shop with a starting pistol loaded with blanks and stole 35 pence, which was later found on the shop floor. Perhaps surprisingly, the Court held that concern for public safety, the applicant's rehabilitation and the fact that the sentencing court hoped for an early release justified the imposition of an indeterminate prison sentence on a minor, which would otherwise have constituted

disproportionate punishment contravening the prohibition on inhuman or degrading treatment or punishment in Article 3 of the ECHR.

In *Weeks*, the ECtHR further considered whether the applicant's recall to prison for breach of his life licence was justified under Article 5.1(a), which permits lawful detention following conviction by a competent court. The Court held that for the purposes of Article 5.1(a), "there must be a sufficient causal connection between the conviction and the deprivation of liberty at issue" (*Weeks*, para. 42). In *Weeks* it was held that the link between the appellant's original conviction and his subsequent recall to prison had not been broken because the life sentence had originally been passed in order to subject him, "a dangerous young man", to a continuing security measure in the interests of public safety and to rehabilitate him (*Weeks*, para. 46). The Court held that "in view of [his] unstable, disturbed and aggressive behaviour, there were grounds for the Home Secretary to have considered that the applicant's continued liberty would constitute a danger to the public and to himself" (*Weeks*, para. 51).

As mentioned previously, the IPP sentence came under attack in both domestic courts and before the ECtHR. The prison system was ill-prepared to deal with the influx of IPP prisoners, resulting in overcrowding and stretched resources. In *R. (on the application of Wells) v. Parole Board* [2010] 1 AC 553, three IPP prisoners challenged their detention on the grounds that the failure of the Secretary of State to provide them with the courses they needed to prove their suitability for release to the Parole Board violated their right not to be subjected to arbitrary detention under Article 5.1. The House of Lords found that although the Secretary of State had failed in his public law duties to the prisoners, their post-tariff detention had not breached Article 5.1 because the purpose of the IPP sentence was not to rehabilitate offenders but to punish them and to protect the public.

The prisoners in *Wells* subsequently brought their case before the ECtHR and, on 18 September 2012, judgment was delivered in *James, Wells and Lee v. UK*. Contradicting the ruling of the House of Lords in *Wells*, the ECtHR found that the grounds for the applicants' detention for the purposes of Article 5.1(a) included both public protection and rehabilitation. The Court therefore concluded that until steps were taken to progress the applicants through the prison system by providing them with access to rehabilitative courses their detention would be arbitrary under Article 5.1(a). The effect of the judgment in *James* is that detention after conviction based on public protection alone is

not permissible under Article 5.1 unless prisoners are also given access to rehabilitative treatments and a route towards release.

The Court in *James* also saw rehabilitation as a means of ensuring that measures of preventive detention are proportional to the need to protect the public from a particular offender. This proportionality requirement was derived from its decision in *M v. Germany* [2009] ECHR 2071. In that case, the Court established the principle that where prisoners have served the punitive element of their sentences and are detained solely on the basis of the risk they pose to the public, there may be a violation of Article 5.1(a) "if there are no special measures, instruments or institutions in place, other than those available to ordinary long-term prisoners, aimed at reducing the danger they present and at limiting the duration of their detention to what is strictly necessary in order to prevent them from committing further offences" (*James,* para. 194).

In the *M* case, the European Court also emphasised the need for a *difference* between the ordinary prison regime and that applying to preventatively detained prisoners. This principle was not taken up in *James*. This is despite the fact that there is very little difference in practice between the punitive and preventative elements of IPP and life sentences. Each is served in the coercive prison environment, and prisoners may have access to rehabilitative treatments both prior to and following the expiry of their punitive tariffs. The distinction between the punitive element of an IPP sentence and the preventative period, while clear in the court room at sentencing, tends to become blurred once the offender reaches prison. Furthermore, the Court in *James* and *M* did not address the proportionality of the *punishment* imposed by an indeterminate sentence, choosing to focus instead on the proportionality of indeterminate sentences to the need for *prevention*. Nevertheless, the judgment in *M* indicates that, following the expiry of the punitive tariff, IPP and life sentenced prisoners continue to be punished on the grounds of their criminal propensities rather than their original crimes. This raises a risk of disproportionate punishment that is not adequately addressed by the Court in *James,* which focused instead on the failure to provide rehabilitative interventions. This issue is addressed in the next section.

(b) Whole life tariffs and punishment

In the case of *Vinter and Others v. UK* [2012] ECHR 61 (C); [2013] ECHR 645 (GC), three prisoners subject to whole life tariffs challenged their detention on the grounds

that their sentences where irreducible and that this constituted inhuman or degrading treatment or punishment under Article 3 by depriving them of any hope of release. This decision further illustrates the Court's approach to "balancing" the offender's right to protection against disproportionate punishment against the public's right to be protected from harm.

In the English and Welsh system, a prisoner subject to a whole life tariff can only be released at the discretion of the Secretary of State if the latter "is satisfied that exceptional circumstances exist which justify the prisoner's release on compassionate grounds" (s.30(1) Crime (Sentences) Act 1997). Previously, the Secretary of State had the power to review whole life tariffs after 25 years but this mechanism was removed by the CJA 2003. Under the terms of Prison Service Order (PSO) 4700, the Secretary of State may exercise his power of compassionate release where "the prisoner is suffering from a terminal illness and death is likely to occur very shortly" or where he "is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke".

In an initial Chamber judgment in *Vinter* [2012] ECHR 61 (C), the Court held that, while in principle questions of appropriate sentencing fell outside the scope of the ECHR, following *Weeks*, grossly disproportionate sentences could violate Article 3. The test of "gross disproportionality" was a strict one, however, likely to be met only on "rare and unique occasions" (*Vinter* (C), para. 89). While detaining a prisoner for his or her natural life would not automatically violate Article 3, the Court held that such a sentence could be grossly disproportionate where the prisoners' detention did not serve any legitimate penological purpose, which included punishment, deterrence, crime prevention and rehabilitation, and where the sentence was irreducible *de facto* and *de iure* (*Vinter* (C), para. 92). The Chamber noted the narrowness of the Secretary of State's policy of compassionate release and found that it "could conceivably mean that a prisoner will remain in prison even if his continued imprisonment cannot be justified on any legitimate penological grounds, as long as he does not become terminally ill or physically incapacitated" (*Vinter* (C), para. 94). However, the Chamber further held that no Article 3 issue had arisen in the applicants' cases as the High Court had found it necessary in view of the seriousness of their crimes to detain them for their whole lives in the interests of punishment and deterrence.

On appeal, however, the Grand Chamber of the ECtHR discerned "clear support in European and international law for the principle that all prisoners, including those serving life sentences, be offered the possibility of rehabilitation and the prospect of release if that rehabilitation is achieved" (*Vinter* [2013] ECHR 645 (GC), para. 114). Furthermore, whole life orders could be inconsistent with the aim of pure punishment because "even when a whole life sentence is condign punishment at the time of its imposition, with the passage of time it becomes […] a poor guarantee of just and proportionate punishment" (*Vinter* (GC), para. 112). This was because if "a prisoner is incarcerated without any prospect of release and without the possibility of having his life sentence reviewed, there is the risk that he can never atone for his offence: whatever the prisoner does in prison, however exceptional his progress towards rehabilitation, his punishment remains fixed and unreviewable" (*Vinter* (GC), para. 112). Henceforth, Article 3 was to "be interpreted as requiring reducibility of the sentence, in the sense of a review which allows the domestic authorities to consider whether any changes in the life prisoner are so significant, and such progress towards rehabilitation has been made in the course of the sentence, as to mean that continued detention can no longer be justified on legitimate penological grounds" (*Vinter* (GC), para. 199).

As Natasa Mavronicola argues, the decision of the Grand Chamber in *Vinter* "is a clear indication that the [European] Court, in contrast with the UK government, does not accept that the retributive (and deterrent) purpose of imprisonment can in itself justify whole life imprisonment" (Mavronicola 2014, p. 303). Purely retributive whole life sentences justified by the seriousness of the offence which, as the government argued in *Vinter*, does not diminish over time, would eliminate the need for rehabilitation and be incompatible with the principle of human dignity underpinning Article 3 (Mavronicola 2014). This is reflected in the statement of Judge Power-Forde in her separate opinion in *Vinter* that even "those who commit the most abhorrent and egregious of acts […] retain the right to hope that, someday, they may have atoned for the wrongs which they have committed" (Vinter (GC), p.53).

The analysis offered by Mavronicola (2014) may be extended to the decisions in *James* and *M* in which the Court also seemed to reject "pure" public protection as a justification for preventive detention without recourse to rehabilitation. In *M*, rehabilitation was also conceived as a means of ensuring the length of detention was proportionate to the need to protect the public. The Grand Chamber in *Vinter* also relies

on the provision of opportunities for rehabilitation and a review mechanism as a means of avoiding disproportionate punishment under Article 3. In this sense, rehabilitation is expected to ensure the proportionality of punishment by allowing an offender who has "atoned" for his wrongs through rehabilitation to be released. Rehabilitation in this sense may therefore be seen as a means for a dangerous offender to redeem himself in the eyes of the law (see further Chapter 7). Dirk Van Zyl Smit and colleagues (2014, p.59) argue that "implicit in the right to a prospect of release is a right to an opportunity to rehabilitate oneself" and that this runs through a line of ECtHR case law, including *James* and *Vinter*. They further argue that the right to rehabilitation should be enshrined in the law of England and Wales in order to comply with the ECHR and that this should be achieved through the inclusion of due process guarantees in Parole Board decisions.

The status of *Vinter* is unclear, however, following the more recent Chamber judgment in *Hutchinson v. UK* [2015] ECHR 111. In that case, the ECtHR appeared to retreat from its previous position on the English and Welsh system while not explicitly overturning the principles set down by the Grand Chamber in *Vinter*. In *R. v. McLoughlin and Newell* [2014] EWCA Crim 188, a specially constituted Court of Appeal (CA) seemingly contradicted the European Court by holding that whole life tariffs were compatible with the ECHR. The CA held that the Secretary of State's discretion was not bound by the terms of PSO 4700 and that his power of compassionate release had to be exercised in conformity with Article 3. It further held that the term "exceptional circumstances" was sufficiently certain and that "compassionate grounds" was "a term with a wide meaning that can be elucidated, as is the way the common law develops, on a case by case basis" (*McLoughlin*, para. 33). In the Court's judgment, "the law of England and Wales therefore does provide to an offender 'hope' or the 'possibility' of release in exceptional circumstances which render the just punishment originally imposed no longer justifiable" (*McLoughlin*, para. 35). The decision set the CA in direct opposition with the Grand Chamber, which rejected similar arguments put forward by the British government in *Vinter*.

In *Hutchinson*, the ECtHR surprisingly held that the Court of Appeal in *McLoughlin* had "specifically addressed" the doubts expressed by the Grand Chamber in *Vinter* and had "set out an unequivocal statement of the legal position" (*Hutchinson*, para. 25). The Court also held that it "must accept the national court's interpretation of domestic law" and that the power of release under s.30 of the CJA 2003, "exercised in the manner

delineated in […] [*McLoughlin*], [was] sufficient to comply with the requirements of Article 3" (*Hutchinson*, para. 25). This was despite the fact that the Grand Chamber had stated categorically in *Vinter* that the clarification of the legal position by way of judicial review, including the quashing of PSO 4700 by the courts, would not be "sufficient to remedy the lack of clarity that exists at present as to the state of the applicable domestic law governing possible exceptional release of whole life prisoners" (*Vinter* (GC), para. 46). More fundamentally, it is unclear how the terms "exceptional circumstances" and "compassionate grounds" may be interpreted to include consideration of progress in rehabilitation, which was central to the Grand Chamber's reasoning in *Vinter*. Although the Court in *Hutchinson* declared itself satisfied with a review mechanism that seemed not to meet the standards set by the Grand Chamber in *Vinter*, it did not explicitly overturn them. The decision in *Hutchinson* does, however, represent a significantly watered-down application of the *Vinter* principles and it is difficult to predict how these will be followed by the ECtHR in future.

(c) Protecting the public

In *Weeks*, the ECtHR accepted that the protection of the public was a "legitimate aim" of the preventive detention of dangerous offenders but it did not articulate this in terms of a "right" of the public to protection (*Weeks* para. 47). In *Vinter*, on the other hand, the Grand Chamber held that "States have a *duty* under the Convention to take measures for the protection of the public from violent crime" (para. 108. Emphasis added). The Court further claimed that states may fulfil their obligation to protect the public "by continuing to detain […] life sentenced prisoners for as long as they remain dangerous" (*Vinter* (GC) para. 108). As authority for this proposition, the Court referred to two cases: *Mastromatteo v. Italy* [2002] ECHR 694 (GC), and *Maiorano and Others v. Italy* ECHR 15 Dec 2009. These cases have received little attention in the literature. They do, however, give a sharp illustration of the limitations of the Court's commitment to the rehabilitation of offenders expounded in *Vinter*, *James* and *M*.

Mastromatteo and *Maiorano* follow on from the earlier case of *Osman v. UK* [1998] ECHR 101 in which the Grand Chamber of the ECtHR held that a positive obligation to protect life arises where it is established that "the authorities knew or ought to have known at the time of the existence of a *real and immediate* risk to the life of an *identified* individual or individuals from the criminal acts of a third party and that they

failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk" (*Osman*, para. 116. Emphasis added). The duty of the state to protect its citizens from harm reflected in *Osman* may be conceptualised as the converse of a "right to security" claimed on behalf of the public. Liora Lazarus argues that "the right to security is inherently ambiguous. It encapsulates on one hand a commitment to rights, which we commonly associate with absence from coercion, but on the other hand a commitment to coercion in the name of individual and collective security" (Lazarus 2012, p.89). She notes that the political rhetoric of "rebalancing" in this context "commonly poses the rights to security of the majority against the rights of minorities which might be infringed" (Lazarus 2012, p.97). Such a balancing metaphor was seen in the DSPD proposals between the right of the public to protection from dangerous offenders and the right of offenders to liberty (see Boateng and Sharland 1999).

For Lazarus, the "key question" that arises in relation to the "right to security" "is whether security is a basic right; or a specific right derived from broader grounding rights or principles; or a meta-right, in other words a right which grounds other rights" (Lazarus 2012, p.97). Lazarus is wary of claims that the "right to security" is a "meta-right" as this tends towards the "usurpation and erosion of existing fundamental rights" in favour of a right to security (Lazarus 2007, p. 344). On the other hand, she is supportive of a "delineated, transparent and narrower notion of the 'right to security' that respects and is grounded in other fundamental rights" (Lazarus 2007, p. 344). She advocates limiting the duty of states to protect the public's right to security to "the development of structures and institutions capable of responding to and minimising 'critical and pervasive threats' to human safety, namely absence from harm in the most central, physical sense of harm to person" (Lazarus 2012, p. 106). For Lazarus, the principle in *Osman* is an example of the narrower type of right to security as it is founded on the right to life recognised by the ECHR. It also appears to meet the "critical and pervasive threat" threshold as it requires a "real" and "immediate" risk to the lives of identified individuals.

Lazarus's discussion is missing the full implications of the State's positive duty to protect individuals from dangerous offenders, however, as she neglects to address the more expansive principle in *Mastromatteo* that has grown out of *Osman*. This principle demonstrates the tendency of the right to security claimed on behalf of "the law's

'innocent' but abstract subjects" to trump the competing rights of the law's "dangerous' but concrete subjects" (Ramsay 2012b, p. 206). The case of *Maiorano*, which followed *Mastromatteo*, is a further demonstration of the weakness of the Court's attachment to the "right to rehabilitation" established in *James* and *Vinter* (Van Zyl Smit *et al.* 2014) in the face of serious re-offending by released prisoners.

In *Mastromatteo*, the applicant's son had been killed in the course of a bank robbery by two prisoners who had absconded while on leave from prison. The applicant argued that the Italian State, by releasing the prisoners, had failed in its duty to protect the life of his son under Article 2. As there was no way of identifying the applicant's son as the likely victim of the released prisoners, the Court held that the State's positive duty to protect life established in *Osman* could also embrace an "obligation to afford *general protection* to society against the *potential* acts of one or of several persons serving a prison sentence for a violent crime" (*Mastromatteo*, para. 69. Emphasis added).

The Court in *Mastromatteo* went substantially further than *Osman* by removing the need for an *identifiable* victim and extending the positive duty to protect life to the public at large. The Court in *Mastromatteo* retained the requirement in *Osman* for a "real and immediate risk" to life and clarified that the state's positive duty did not extend to an "obligation to prevent every possibility of violence" (*Mastromatteo*, para. 68). Rather, the duty "must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources" (*Mastromatteo*, para. 68). On the facts in *Mastromatteo*, the Court found that the Italian system of prison leave provided sufficient protection for society and that there had been no failings in the decision to release the prisoners.

By contrast, in the Chamber decision of *Maiorano*, the ECtHR found the Italian authorities had failed in their duty to protect life under Article 2 by granting prison leave to a "dangerous" "repeat offender" convicted of "exceptionally brutal crimes" who went on to murder two women. Thirty years previously, the prisoner had been convicted of kidnapping, rape, murder and attempted murder in similar circumstances. The Italian government argued before the ECtHR that while the prisoner in question had breached the conditions of his release by associating with other offenders there was no

indication of his murderous intentions. The murders of the victims were unconnected with the drug trafficking activities the prisoner seemed to have resumed upon his release. The Italian government further argued that the crimes were not foreseeable under the principles in *Osman*, as the prisoner explained they had been committed for pleasure and to re-create the offences he had committed thirty years previously. In addition, the government argued that, by their nature, measures aimed at the gradual social reintegration of offenders involved a risk of recidivism. The system could reduce that risk but it could not be completely eliminated. Following *Mastromatteo*, the government contended that "the mere possibility that a person who had killed once could kill again" could not constitute a "real, foreseeable and concrete" risk to life. "To conclude otherwise would be to rule out in advance any measure of social reintegration for killers" (*Maiorano*, para. 89, my translation).

The Court in *Maiorano* found the Italian government's arguments unconvincing. It noted that the case fell under the broader principle in *Mastromatteo* as there was no way of identifying the two victims in advance. Despite showing some improvement in prison, the Court noted that the prisoner had committed further crimes, including obtaining weapons and holding a prison guard hostage in an escape attempt. Furthermore, he had demonstrated "a tendency to disrespect the law and authority" (Registrar of the ECtHR 2009). The Court held that by granting the prisoner day release "despite his criminal record and behaviour in prison" and failing to act on information that he had resumed his criminal activities, the Italian authorities had breached their duty of care under Article 2 of the Convention (Registrar of the ECtHR 2009). While the Court approved of Italy's measures of social reintegration and safeguards in general, it held that they had not been adequately followed on this occasion.

The Court's decision in *Maiorano* represents a watering down of the requirement that the individual pose a "real and immediate risk" to life and demonstrates the potential for the positive duty doctrine to undermine the Court's own commitment to the rehabilitation of offenders. Furthermore, it shows that the Court is not immune to the "hindsight bias" commonly found in inquiries following homicides by released patients (Szmukler 2000, p.8). As Szmukler argues, "with hindsight an outcome begins to look inevitable; a plausible chain of causes can be easily traced backwards through time" and awareness of the "multitude of possibilities that present themselves in 'real', forward-moving time" is easily lost (Szmukler 2000, p.8). The similarity of the 2005 murders to

the crimes committed by the prisoner in 1975, coupled with the failure to recall the prisoner for breaching his release conditions by associating with other criminals, may have given the impression that the offences were foreseeable and therefore preventable. In *Maiorano*, the Court thus appeared to disregard the constraints laid down in *Mastromatteo* including the "unpredictability of human conduct" and the difficulties in policing modern societies.

The Court's focus in *Maiorano* on the gravity of the prisoner's previous offences also appears to be at odds with the principle in *Vinter* that even those convicted of the most heinous crimes should not be deprived of the hope that they will one day have "atoned" for their wrongs. The risk-averse stance of the Court in *Maiorano* also casts doubt on the claim in *Vinter* that rehabilitation can provide a means of avoiding grossly disproportionate punishment and the claim in *James* and *M* that it can be expected to render length of detention proportionate to the risk the individual poses to the public. Coupled with the low predictive accuracy of current risk assessment instruments, the paradoxes associated with assessing progress in personality disordered offenders and the weak evidence base for the effectiveness of rehabilitative interventions in reducing risk, these principles appear to present little resistance to the excessive use of preventive detention with personality disordered offenders.

6. A Right to Security and a Duty to Engage in Rehabilitation?

(a) A duty to reassure a vulnerable public

At the time the DSPD proposals were developed, the general duty to protect life in *Mastromatteo* had not yet been articulated by the ECtHR. Nevertheless, the narrower principle in *Osman* gave Mike Boyle of the Home Office grounds to assert that the ECHR "impose[d] upon states an obligation to protect the public from predictable dangers that individuals may cause" (Select Committee on Health 2000b, 18 May 2000, para. 636). On the other hand, John Wadham, Director of Liberty, stated that the rule in *Osman* did not force government to take the steps outlined in the DSPD proposals because it required "a situation where the authorities know that there is an individual who is going to take a specific action, not that an individual might, in two years' time, or three years' time, take a certain action" (Home Affairs Committee 2000b, Minutes of

Evidence, 23 November, para. 7). The now more expansive principle in *Mastromatteo* seems to support former Minister Paul Boateng's claim that society had a more general "right" to protection from dangerous personality disordered individuals and that the government had a duty to provide that protection (Boateng and Sharland 1999, p.6). In *Maiorano*, as in the DSPD proposals, the right of the public to protection also takes clear priority over the right of the offender to rehabilitation and social integration.

Peter Ramsay argues that it is the vulnerability of potential victims of crime, "the law's 'innocent' but abstract subjects", that underlies official justifications for the prioritisation of their interests over those of potential offenders, the law's "dangerous' but concrete subjects" (Ramsay 2012b, p. 206). This gives rise to an "obligation" on behalf of dangerous offenders "to reassure the authorities that they are not a significant risk" (Ramsay 2012c, p.134). In the context of the public's right to security and the government's "duty" to protect life, therefore, instead of having a "right" of access to rehabilitation, offenders have a duty to engage in rehabilitation in order to demonstrate their suitability for release.

According to Ramsay, the duty to reassure arises from the "ideology of vulnerable autonomy" (Ramsay 2012a, p.84). This ideology was the confluence of three theories that strongly influenced the New Labour programme: Anthony Giddens' Third Way, communitarianism and neoliberalism. All three theories "assume that the autonomy of citizens is vulnerable to insecurity caused by others' hostility and indifference" (Ramsay 2012a, p.84). The "ideology of vulnerable autonomy" imposes "obligations to be aware of others' vulnerability" in the face of uncertainties generated by life in modern society in the hope that "the lack of social cohesion engendered by the atomistic neoliberal economic and social order might be ameliorated" (Ramsay 2012a, p.111).

According to Giddens, as tradition and custom have gone into decline, they have been replaced by "a new individualism" (Giddens 1991, p.40). In this context, "ontological security" operates as a "protective cocoon" and is essential to allow individuals to develop a stable sense of self and to pursue self-actualisation free from existential anxiety (Giddens 1991, p.40). This "cocoon" is threatened by the selfish actions of others and individual autonomy is therefore dependent on the choices of those around us. In Giddens' theory, the role of the new welfare state is "not in essence an economic concept, but a psychic one" in which the state seeks to ensure security as an aspect of

psychological wellbeing (Giddens 1998, p.117). Fear of crime in Giddens' theory presented a particular threat to autonomy and "freedom from the fear of crime" was therefore conceived as "a major citizenship right" (Giddens 2002, p.17).

Through claiming to pursue the protection of the public through preventive detention of the dangerous, the DSPD proposals sought to protect the "right" of the public not only to actual protection by the state but also to freedom from fear of crime. One civil servant in interview stressed that "ministers are particularly concerned about public perception. And public perception, rightly or wrongly, emphasises concerns about danger presented by particular individuals". This gave rise to the "atmosphere of needing to demonstrate that the government was doing something" about an issue of concern that was "exacerbated by concerns about the Michael Stone case" (Civil Servant). Those in the DSPD group would also have to live up to their duties as citizens by reassuring others that they no longer posed a threat by actively participating in the rehabilitative interventions that aimed to reduce their risk to the public.

The duty to engage in rehabilitation was given the status of an administrative requirement in *Guntrip* and *Falconer*. It also appears in the rhetoric surrounding the revival of rehabilitation as an aim of the criminal justice system in recent years. For Elaine Genders and Elaine Player, the low priority of prisoners' rights in Britain is the result of their status of "'less eligibility', whereby the notion of universality of rights is replaced by a concept of desert that links access to the assessment of personal virtue" (Genders and Player 2014, p.451). As the authors point out, in the Coalition government's "Rehabilitation Revolution" (Ministry of Justice 2010a) "prisoners' access to services is framed within a discourse of obligation rather than one of entitlement" (Genders and Player 2014, p.451).

Meeting the "duty" to engage in rehabilitation may also be characterised as a condition of citizenship. Zedner argues that the "recasting of citizenship as a status that has to be earned" in immigration law can also be seen in domestic criminal law (Zedner 2010, p.389). "Irregular citizens", including sexual and violent offenders, are "consigned to a probationary or provisional status" as "citizenship rights of participation and protection are made conditional upon compliance with prescribed norms and upon conformity with specified requirements" (Zedner 2010, p.389). Those who fail to comply are "barred temporarily or indefinitely from full citizenship" through exclusionary measures

(Zedner 2010, p.390). Appeals to rehabilitation as a means of avoiding disproportionate punishment conceal the unequal and coercive nature of the "balance" being struck between the "law-abiding" citizen and the "irregular" or non-citizen.

(b) Liberalism, security and "balance"

The ECtHR case law implies that, in preventive detention, the right to life of one individual is pitted against the right of another not to be arbitrarily deprived of his liberty. In its judgments in *M*, *James* and *Vinter*, the Court was willing to permit preventive detention so long as rehabilitative interventions were made available to mitigate the effects of long-term incarceration and to ensure that the length of detention served was not disproportionate to the risk prevented by the individual. However, the expansive duty of the state to protect the general public from released prisoners established in *Mastromatteo* and the risk-averse judgment in *Maiorano* demonstrate the weakness of the ECtHR's commitment to the rehabilitation of offenders in the face of threats to the security of the public. The *Maiorano* case also implies that, like in the DSPD proposals, the "balance" between competing rights is tipped in favour of the public.

Mark Neocleous argues that the idea of a "balance" between security and liberty "is essentially a liberal myth […] that in turn masks the fact that liberalism's key category is not liberty, but security" (Neocleous 2007, p.131). He argues that liberal theories of government, beginning with John Locke, left room for the exercise of prerogative power and that this allowed the earlier tradition of "reason of state" to enter into liberal governance. According to Neocleous, "reason of state treats the sovereign as *autonomous* from morality; the state can engage in whatever actions it thinks right, so long as they are done according to 'necessity' and/or 'the public good'" and, ultimately, to protect the state itself (Neocleous 2007, p.137). By the late 18th century, "liberty" and "security" became synonymous with each other and there was therefore no need to strike a "balance" between them (Neocleous 2007, p.141). For Neocleous, "security became the cornerstone of the liberal mind, which came to identify security with the freedom and liberty to pursue one's individual self-interest" (Neocleous 2007, p.142). Problematically, however, the liberal "commitment to security leaves liberalism with no defence against authoritarian or absolutist encroachments on liberty, *so long as these are conducted in the name of security*" (Neocleous 2007, p.143, emphasis in original).

According to Neocleous, for liberal politicians today, rather than being expressed in "reason of state" terms, "any attempt to limit liberty on the grounds of security has to be couched in terms of the rule of law and basic rights" (Neocleous 2007, p.143). Appeals to the public's "right" to security, in the subjective and objective senses, may be seen in this light. The case law of the ECtHR goes further in *Vinter* by presenting rehabilitation and periodic review of detention as a means of avoiding the disproportionate punishment that would otherwise be imposed by indefinite detention under a whole life tariff. However, in the framework of the ECHR, both the right to life, enshrined in Article 2, and the right not to be subjected to inhuman or degrading treatment or punishment, enshrined in Article 3, are unqualified rights. This implies that there should be no trade-off between the two. In *Maiorano*, however, security may be seen to take priority over the right of the offender to social reintegration and states are permitted to detain indefinitely those who are deemed to pose too high a risk.

Ramsay argues that the emergence of preventive measures against those who fail to reassure others of their harmlessness indicates that "the criminal law's threats are premised on their own inadequacy" (Ramsay 2012a, p.212). Contrary to Garland's "limits of the sovereign state" thesis, Ramsay argues that "the problem of the expansion of penal control is the result of the actual decline of sovereign authority rather than of the political pursuit of its myth" (Ramsay 2012a, p.212). The dangerous personality disordered offender may be understood as a particular threat to the authority of the criminal law, as he appears to be undeterred by the prospect of punishment and unpersuaded by the law's normative force. The historical use of preventive detention to govern dangerous offenders is not surprising, therefore, as the presence of such individuals undermines the state's authority to control crime through the pronouncement of norms and penalties.

Rather than a balance between conflicting rights, therefore, the prioritisation of public protection may be better understood a means of protecting the authority of the state, which takes precedence over individual rights. Rather than a question of balancing "rights", "the public good" trumps the rights of the offender. This public good is found not only in objective security, or freedom from actual harms, but also in subjective security, or freedom from the fear of harm (Ramsay 2012d). As in the welfare state, in respect of dangerous offenders, the "new" state retains the "responsibility of being both the ultimate and the proximate guarantor of security" (Rose 2000, p.327). However, by

assuming responsibility for protecting the public from dangerous offenders and seeking to eliminate risk, the government sets itself up for failure as atrocities inevitably occur.

If liberalism really does prioritise security over liberty, a question arises as to why the provision of rehabilitative interventions is required at all. Particularly informative here is Ian Loader's (2006) study of the "platonic guardians" who were responsible for criminal justice policy in the middle decades of the 20th century. According to Loader, these "liberal elites" were "wedded to the belief that government ought to respond to crime (and public anger and anxiety about crime) in ways that, above all, seek to preserve "civilized values" (Loader 2006, p.563). In Loader's account, rather than being the "organizing principle" of "penal-welfarism", the commitment to rehabilitation evinced at this time was "contingently attached" to the broader "project of being civilized" (Loader 2006, p.564-565). The appeal of rehabilitation was two-fold. First, it "gave a humanizing rationale to the otherwise troubling and distasteful practice of penal detention" and, second, it "offer[ed] a scientifically grounded and effective means of helping offenders return to the fold of citizenship" (Loader 2006, p.565).

The fact that the DSPD initiative was intended to promote offender re-integration seems to reflect the "civilizing" purpose described by Loader (2006). As argued in Chapter 2, the DSPD initiative was sparked off by a group of civil servants in the Home Office and Department of Health and led by a politician, Paul Boateng, who was concerned with civil liberties and human rights. Through the compromise at the centre of the 1999 proposals, the "wasteful" "damaging" or "distasteful" (Loader 2006, p.565) practice of imprisonment was made more palatable by the prospect of tailored treatments that would alleviate the distress of those in the DSPD group and allow them to progress towards freedom. Policymakers were concerned not to "write off" the DSPD group, implying that the dangerous were potentially redeemable by reformative means. Nevertheless, where the reduction of risk through treatment was found to be impossible, the safety of the public would prevail. In the final chapter of this thesis, the assumptions underlying the framework governing dangerous personality disordered offenders will be interrogated further and it will be argued that rehabilitation and preventive detention may be seen as responses to the redeemable and irredeemable offender.

7. Conclusion

The extensive coercive powers outlined in this chapter may be seen to exploit the mobile boundaries of a legal framework that prioritises the rights of a nebulous "public" to protection from uncertain harms over the rights of concrete offenders to liberty and freedom from disproportionate punishment. At first glance, the Grand Chamber's stance in *Vinter* appears to be progressive and protective of individual prisoners' rights and to establish a right of access to rehabilitation. The *Mastromatteo* and *Maiorano* cases demonstrate, however, that the European Court, like the British government, is also willing to sacrifice the right of offenders to social re-integration to the pursuit of public protection. This indicates the weakness of liberal human rights principles in the face of serious offending by released prisoners.

The case law suggests that the ECtHR prioritises the public's right to security, grounded in the right to life under Article 2, over the offender's right not to be subjected to disproportionate punishment under Article 3. The priority placed on the protection of the public over the rehabilitation of the offender suggests that, rather than striking a balance between competing individual rights, the "bargain" in fact trades individual liberty and the right not to be subjected to grossly disproportionate punishment for collective security. The low priority given to the rights of offenders is a theme that continues through the body of mental health law considered in the next chapter.

Chapter 6: Dangerous Personality Disordered Offenders in the Mental Health System

1. Introduction

As argued in earlier chapters, the reforms to the MHA 1983 brought by the MHA 2007 were in many respects motivated by a concern to facilitate the detention and treatment of the DSPD group in secure hospital. However, the effects of the MHA 2007 have reached far beyond this small group to subject a large range of mentally disordered individuals to compulsory powers. Furthermore, access to defences and pleas on the grounds of mental disorder, including unfitness to plead, insanity and diminished responsibility, is particularly limited for personality disordered offenders, and reform proposals tend to further entrench this pattern. Thus there is a tendency for courts to view personality disordered offenders as at least partially culpable for their disorders and therefore deserving of punishment. This is despite empirical evidence indicating that the volitional deficits of personality disordered offenders may prevent them from acting towards others "in the spirit of brotherhood" (Peay 2011a, p.232).

The limited nature of defences relating to mental disorder has been partially alleviated by the greater availability of hospital disposals as sentencing options. Despite the reforms introduced by the MHA 1983, however, personality disordered offenders are judged to be unsuitable for hospital disposals due to the doubtful "treatability" of their disorders and the risks they pose to the public. The greater availability of treatment for personality disorder in prisons following the introduction of the DSPD programme seems to have contributed to the view of the CA in the recent decision of *Vowles* that a prison sentence is the correct response to personality disordered offenders who pose a risk to the public. On the other hand, "appropriate medical treatment" is interpreted broadly when it comes to detaining personality disordered offenders in hospital on the grounds of risk. The result for individuals in the personality disorder category is that their mental disorders, while insufficient to exculpate them, allow them to be detained and treated in the hospital system for the protection of society. It is argued that this risk averse and punitive stance towards personality disordered offenders fails to take into account the particularities of their disorders and jeopardises their wellbeing.

2. Defences and Pleas Relating to Mental Disorder

Rates of mental disorder are high amongst prisoners. In a study of 1,435 newly sentenced prisoners commissioned by the Ministry of Justice, 10% were identified as "likely to have a psychotic disorder", 61% a personality disorder and over one third reported "significant symptoms of anxiety or depression" (Stewart 2008, p.iii). From the same sample, 57% of female and 48% of male prisoners reported that they had accessed mental health treatment in the year prior to conviction and 49% of women and 18% of men said they needed help for mental health problems in prison (Light *et al.* 2013, p.20). These figures indicate that mentally disordered offenders are not being adequately filtered out of the prison system at sentencing.

As will be seen below, the access of personality disordered offenders to defences based on mental disorder is severely limited, and reform proposals tend to further entrench this pattern. This indicates that personality disordered offenders tend to be found by courts to be criminally responsible despite the volitional deficits and emotional problems linked to their disorders. Drawing on the doctrine of diminished responsibility, personality disordered offenders are sometimes considered by the courts to be "partially culpable" for their crimes. However, this finding tends to result in a punitive rather than a therapeutic disposal.

(a) Unfitness to plead

Under s.4 of the Criminal Procedure (Insanity) Act 1964, the question of fitness to plead is to be determined as soon as it arises by the judge without a jury on the written evidence of two or more medical practitioners. If the defendant is found unfit to plead the trial may not proceed, and under s.4A of the 1964 Act the jury must determine whether the accused did the act or made the omission with which he is charged. According to the House of Lords, the purpose of the proceedings under s.4A is "to strike a fair balance between the need to protect a defendant who has, in fact, done nothing wrong and is unfit to plead at his trial and the need to protect the public from a defendant who has committed an injurious act which would constitute a crime if done with the requisite *mens rea*" (*R. v. Antoine* [2000] UKHL 20, [2001] 1 AC 340, at 375).

Prior to the reforms introduced by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, a finding of unfitness to plead was followed by confinement in psychiatric hospital until release was granted by the Home Secretary. Now, a range of disposals are available, including absolute discharge, supervision orders and hospital orders with or without restrictions (s.5 and 5A Criminal Procedure (Insanity) Act 1964). The number of findings of unfitness have increased year-on-year since the 1991 reforms came into force, rising from 13 in 1993 to 31 in 1994 and reaching a high of 118 in 2008 (Mackay 2016, p.3-4). Between 2002 and 2014, the annual average was 100.6 findings (Mackay 2016, p.4). Numbers remain relatively low, however, given the rates of mental disorder amongst the prison population mentioned previously.

The test for unfitness is found in the common law and derives from the case of *R. v. Pritchard* (1836) 7 C & P 303. A defendant may be found unfit where he lacks any of the following: "the ability to plead to the indictment, to understand the course of the proceedings, to instruct a lawyer, to challenge a juror and to understand the evidence" (Law Commission 2010, para. 2.46). The Law Commission is highly critical of the *Pritchard* test as it "places a disproportionate emphasis on cognitive ability" and fails to "take any or sufficient account of factors such as emotion or volition" or "of the capacity of the accused to make decisions relating to his or her trial" (Law Commission 2010, para. 3.23).

In its recent report to the government, the Law Commission advocated that there should be "a full trial wherever fair and practicable" and that removal from the trial process as a result of unfitness should take place "as a last resort" (Law Commission 2016, para. 1.11-1.12). In the Commission's view, defendants should be supported to participate in their trials as fully as possible as the trial process ensures the protection of due process rights and allows for the full range of sentencing disposals (Law Commission 2016). Given the deficiencies of the *Prichard* test, the Law Commission proposes a substitute modelled on the Mental Capacity Act (MCA) 2005. The aim of the MCA 2005 is to allow decisions to be made on behalf and in the best interest of individuals who lack capacity to make them.

The proposed new test for unfitness to plead is very similar to the test of capacity contained in the MCA 2005 but specifically focuses on the accused person's

understanding of the charge and trial process and his or her ability to make decisions during the course of the trial. Under the proposed test:

> A defendant is to be regarded as lacking the capacity to participate effectively in a trial if the defendant's relevant abilities are not, taken together, sufficient to enable the defendant to participate effectively in the proceedings on the offence or offences charged.
>
> An accused should be found to lack capacity if he or she is unable:
>
> (1) to understand the information relevant to the decisions that he or she will have to make in the course of his or her trial,
>
> (2) to retain that information,
>
> (3) to use or weigh that information as part of decision making process, or
>
> (4) to communicate his or her decisions
>
> (Criminal Procedure (Lack of Capacity) Bill, s.3(2); s.3(5)).

While the Commission did not analyse the issue of psychopathy or personality disorder in detail, it acknowledged that the volitional or emotional deficits associated with the disorders could affect a defendant's decision-making capacity (Law Commission 2010, para. 3.38-39).

Characteristics of ASPD and psychopathy include impulsivity, grandiosity, a lack of remorse, failure to learn from experience, manipulativeness and failure to accept responsibility for one's actions (American Psychiatric Association 2013; Hare 1991). Individuals affected by these disorders may have a good cognitive understanding of the trial process but their capacity to make rational decisions about the conduct of their defence may be impaired by their personality traits. In the case of *R. v. Diamond* [2008] EWCA Crim 923, for example, the defendant, who had previously been diagnosed with a personality disorder, pleaded not guilty to murder instead of pleading guilty to manslaughter on the grounds of diminished responsibility, seemingly in the belief he would be acquitted.

Paranoid personality traits may also cause a defendant to distrust his legal team and the impartiality of the court and lead to inappropriate pleading. In *R. v. Moyle* [2008] EWCA Crim 3059, there was fresh psychiatric evidence that the appellant was suffering

from paranoid schizophrenia and delusions of persecution at the time of the trial that influenced his decision not to raise the defence of diminished responsibility.

Borderline personality disorder, also prevalent amongst DSPD patients and prisoners (Burns *et al.* 2011), is characterised by depressiveness, impulsivity, self-harming behaviour and emotional lability (American Psychiatric Association 2013). These symptoms may cause defendants to plead guilty in the belief that they deserve punishment. In the case of *R. v. Murray* [2008] EWCA Crim 1792, a woman suffering from paranoid schizophrenia pleaded guilty to murder, even though a plea of diminished responsibility would have been available, as she felt overwhelming guilt at having killed her young daughter and wished to be punished for her crime.

According to the Law Commission, if the test it proposes were adopted, "paradigmatic cases such as *Moyle*, *Diamond* and *Murray* would presumably result in a finding that the accused lacks decision-making capacity" (Law Commission 2010, para. 3.37). However, some unresolved issues remain regarding how a capacity-based test would apply to defendants with personality disorder. When the Richardson Committee proposed a new capacity-based framework for a new MHA it foresaw that compulsory powers would be unlikely to apply to personality disordered patients because "many […] may be found to have the necessary capacity to choose for themselves whether to accept care and treatment" (Department of Health 1999a, para. 4.15). This is confirmed by the data in the IDEA study, which found that 94% of patients and prisoners on the DSPD programme had the capacity to consent to treatment based on a standardised testing instrument entitled *Thinking Rationally about Treatment* (TRAT) (Grisso and Appelbaum 1993, see Burns *et al.* 2011, p. 93). Although this instrument is not based on the criteria of the MCA 2005, it does include analogous concepts such as consequential thinking, complex thinking, generating consequences, weighing consequences, and expressing a choice (Burns *et al.* 2011, Table 3.13). A capacity-based test of unfitness to plead may therefore find that offenders with personality disorder have the capacity to make decisions about their trial even though their choices may be influenced by their disorders. While the Law Commission does refer in its consultation paper to the impact of emotions and volition on the capacity of defendants to make decisions, the test does not explicitly incorporate those factors. The result may therefore be another test of cognitive function that does not adequately take into account the impairments of personality disordered offenders, who may be left outside its protection.

(b) Insanity

Where a defendant is found fit to plead at trial (or the issue was not raised) but he was mentally disordered at the time of the offence, he may plead not guilty by reason of insanity (NGRI). Under the *M'Naghten* rules, the burden rests upon the accused to prove on the balance of probabilities that at the time of the offence, he was "labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong" (*Queen v. M'Naghten*, 8 Eng. Rep. 718 [1843]). As was the case with unfitness to plead, prior to the 1991 Act, the only disposal available to the court upon a finding of insanity was indefinite detention in psychiatric hospital until release was ordered by the Home Secretary. Now a range of disposals is available. However, where the charge is murder and the defendant is found NGRI, the court is bound to impose a hospital order with restrictions under s.37 and s.41 of the MHA 1983.

A personality disorder is a "disease of the mind" falling within the *M'Naghten* rules. The first part of the test, whether the defendant did not "know the nature and quality of the act he was doing", has been very narrowly defined and is rarely used in practice (Law Commission 2013, para. 1.48). In the case of *R. v. Codère* (1917) 12 Cr App Rep 21, it was held that "nature and quality" meant that a defendant could not plead insanity if he was aware of the physical aspects of his act, regardless of whether or not he was aware of its moral aspects. The second part of the test, whether the defendant knew that what he was doing was "wrong", is more frequently used. However, wrongfulness has been interpreted in the narrow sense of legally rather than morally wrong (*R. v. Windle* [1952] 2 QB 826). This definition may pose a particular barrier to personality disordered defendants who may have a good cognitive understanding of what legal rules state but who may not respond to moral reasons for restraint (see Morse 2008; Peay 2011a).

Since the introduction of the 1991 reforms, the annual average number of findings of NGRI has been steadily increasing, rising from an average of 8.8 per year between 1987 and 1991 to 24.4 between 2007 and 2011 (Law Commission 2012, para. E.5). The numbers of defendants found NGRI nevertheless appear low when we consider the rates of mental illness and mental disorder amongst the prison population. The rate of successful pleas of NGRI amongst personality disordered defendants is even lower, as

between 1975 and 1988 there were just three findings of NGRI where the diagnosis was personality disorder and, in later research, there were no successful pleas with this diagnosis (Law Commission 2012, para. 3.38).

In their responses to the Law Commission's consultation paper on insanity, legal and medical practitioners acknowledged that while "academic criticisms of the defences are justified", in practice they "work round the problems" (Law Commission 2013, para. 1.10). Thus, "practitioners take a pragmatic approach, and achieve the 'correct' outcome, in the view of the practitioner and/or the accused, without having to consider the insanity defence" (Law Commission 2013, para. 1.82). In light of this, the Commission concluded that "while there are a great many people convicted of offences who have mental health problems and/or learning difficulties, the number who completely lack criminal responsibility as a result is small […] and it may be that this would remain the case even if the defences were brought up to date" (Law Commission 2013, para. 1.83). The proportion of prisoners affected by mental disorder casts doubt on the Commission's assertion that the narrowness of the insanity defence causes few problems in practice.

The Commission's proposals for a new defence of "not criminally responsible by reason of recognised medical condition" (Law Commission 2013, para. 3.16) tend to exclude personality disordered offenders further from the defence. The proposed new defence is based on the existing defence of diminished responsibility. It would require the defendant to demonstrate that, at the time of the offence, he was affected by "a total lack" of capacity to do one or more of the following: "rationally to form a judgment about the relevant conduct or circumstances; to understand the wrongfulness of what he or she is charged with having done; or to control his or her physical acts in relation to the relevant conduct or circumstances" (Law Commission 2013, para. 4.126-7). This lack of capacity must arise from "a qualifying recognised medical condition" (Law Commission 2013, para. 4.126).

As it covers volitional as well as cognitive capacities, the test may be expected to draw more mentally disordered offenders into the defence of insanity. However, the Law Commission deliberately excludes from the definition of "recognised medical condition" disorders, such as ASPD, that are "characterised solely or principally by abnormally aggressive or seriously irresponsible behaviour" where "the evidence for the

condition is simply evidence of what might broadly be called criminal behaviour" (Law Commission 2013, para. 1.90). It is notable that the Law Commission purports to use the same definition that was formerly used to bring certain personality disordered individuals within the ambit of the old MHA 1983 to exclude them from a new insanity defence. Part of the formula for the new test derives from the former s.1(2) of the MHA 1983, which defined "psychopathic disorder" as "a persistent disorder or disability of mind […] which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned".

Following the amendments to the MHA 1983, all personality disordered individuals are encompassed by the definition of "mental disorder" and potentially subject to compulsory powers. Yet, many of those with personality disorder or psychopathy would remain outside the protection that would be afforded by the proposed new insanity defence. Thus it appears that personality disordered offenders are doubly disadvantaged by the nature of their disorders. This theme recurs later in the choice between hospital disposals and punitive prison sentences discussed later in this chapter.

(c) Diminished responsibility

Diminished responsibility is a partial defence to murder first introduced by s.2 of the Homicide Act 1957. The doctrine was adopted from Scottish law and was intended to "[inject] flexibility" into the law of insanity and "counter the effects of the narrow, cognitive M'Naghten test" (Loughnan 2012, p.234). The defence was reformulated in s.52(1) of the Coroners and Justice Act 2009. Under the reformed defence, a defendant charged with murder will see his charge reduced to one of manslaughter if he can show that, at the time of the killing, he was "suffering from an abnormality of mental functioning" that "arose from a recognised medical condition" and that this "substantially impaired [his] ability to […] understand the nature of [his] conduct; to form a rational judgment [or] to exercise self-control" and "provides an explanation for [his] acts and omissions in doing or being a party to the killing" (s.52(1) CJA 2009). When accepted, the defence results in conviction for manslaughter, thus avoiding the mandatory life sentence for murder and leaving the choice of sentence to the judge's discretion. The maximum sentence for manslaughter is life imprisonment and hospital disposals are also available.

A defence of diminished responsibility was accepted under the previous law in the case of *R. v. Byrne* [1960] 2 Q.B. 396. In that case, the appellant, who had killed a young woman, was found to be a "sexual psychopath" suffering from an abnormality of the mind such that he was unable to resist his impulses. The CCA reduced Byrne's murder conviction to one of manslaughter but left in place his life sentence as this was "the only possible sentence given [his] tendencies" (*Byrne*, p.405). Although the reformed defence of diminished responsibility was partly modelled on the directions of the court in *Byrne*, according to Ronnie Mackay, personality disorder "is now unlikely to fall within the new plea unless the defendant's ability to exercise self-control can be proved to have been substantially impaired" (Mackay 2010, p.297). Claims on this ground are subject to the requirement that the defendant's conduct be fully or partially caused by his mental abnormality, which may constitute a further hurdle for personality disordered defendants to overcome.

As indicated in the introduction to this thesis, the nature of the association between offending and personality disorder is unclear and the multiplicity of confounding factors makes any causal relationship difficult to determine (Duggan and Howard 2009; Howard 2015). Furthermore, as Jill Peay argues, it is not easy to "draw a bright dividing line between those who do not and those who cannot control their behaviour" (Peay 2011a, p.234). For Peay, "factors such as a low tolerance for frustration and impulsivity, combined with substance misuse facilitated by impaired moral reasoning, can make for a murky picture" (Peay 2011a, p.234). However, these "maladaptive traits will be placed into a context where, because those with personality disorder remain capable of instrumental reasoning to achieve their goals, the capacity to respond to moral reasoning will remain, at least in part" (Peay 2011a, p.234; see also Glannon 2008). It may therefore prove difficult for offenders in the personality disorder category to prove a sufficient causal connection between their disorders and their offending for a plea of diminished responsibility to succeed. Furthermore, as diminished responsibility is only available as a partial defence to murder its practical effect is limited.

Prior to the 2009 reforms, the numbers of successful pleas of diminished responsibility on the grounds of personality disorder were relatively low, at 10% in 2005, compared to 28% for paranoid schizophrenia (Ministry of Justice 2009b, p. 15). No more recent statistics could be found on the rates in respect of personality disordered offenders, but Mackay (2010) argues that they may be expected to be as low if not lower following the

reforms. Again, the effect of reform may be to exclude more personality disordered offenders from defences based on mental disorder. Nevertheless, the numbers indicate that personality disordered offenders may be more successful in raising diminished responsibility than insanity or unfitness to plead. Courts have derived a concept of "partial responsibility" from the doctrine of diminished responsibility and this has been used by in determining sentence even in non-murder cases, as discussed below.

3. The Impact of the MHA 2007: From "Treatability" to "Appropriate" Treatment

(a) Treatability: A question of culture or law?

Under the old MHA 1983, patients suffering from "psychopathic disorder" could only be detained in hospital where treatment was "likely to alleviate or prevent a deterioration of [their] condition". This became known as the "treatability" test and was targeted for abolition by the DSPD proposals as it was regarded as a barrier to the detention of dangerous personality disordered offenders in hospital to protect the public. Rather than removing the test completely, however, the MHA 2007 substituted the requirement that "appropriate medical treatment" be "available" to the patient in hospital and that its "purpose" be "to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations" (s.145(4) MHA 1983). This is similar to the old test but sets a lower standard as "purpose is not the same as likelihood" (Department of Health 2008, para. 6.4). To satisfy the availability requirement, "treatment must actually be available to the patient [and it] is not sufficient that appropriate treatment could theoretically be provided" (Department of Health 2008, para. 6.13). "Medical treatment" is defined broadly and includes "nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care" (s.145(1) MHA 1983).

Under the former MHA 1983, the courts already took a broad view of what constituted "treatment" for personality disorder. In *Hutchison Reid v. Secretary of State for Scotland* [1999] 2 A.C. 512, which concerned Scottish legislation similar to the MHA 1983, the House of Lords (HL) held that even though the patient was not receiving treatment for his personality disorder, his detention in a secure hospital "was preventing a deterioration of his condition because his abnormally aggressive or seriously

irresponsible behaviour was being controlled or at least being modified" (*Hutchison Reid*, p. 531). Furthermore, it held that the definition of "medical treatment" was "wide enough to include treatment which alleviates or prevents a deterioration of the symptoms of the mental disorder, not the disorder itself which gives rise to them". The fact that the patient's anger management showed improvement in the structured and medically supervised environment of the hospital was enough to satisfy this test (*Hutchison Reid*, p. 531).

This position was approved by the ECtHR in the subsequent case of *Hutchison Reid v. UK*, in which it was held that "compulsory confinement" "may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons" (*Hutchison Reid v. UK*, para. 52). In principle, however, detention under Article 5.1(e) will only be lawful "if effected in a hospital, clinic or other appropriate institution" (*Aerts v. Belgium*, [1998] ECHR 64, para. 46).

As noted previously, the vast majority of hospital patients in the MEMOS study had been transferred to hospital from prison under s.47 MHA 1983 (Trebilcock and Weaver 2010a). Just 10% of the patients had been given a hospital order at sentencing (Trebilcock and Weaver 2010a, p.31). This reflects the fact that personality disordered offenders are often found criminally responsible by the courts and are rarely found not guilty by reason of insanity (NGRI) or unfit to plead. By the end of the MEMOS study period, 73% of the indeterminate sentenced patients had passed their tariff expiration date and 85% of those given a determinate sentence had passed their non-parole date (Trebilcock and Weaver 2010a, p.40-41). This indicates that the hospital units were being used to detain high-risk offenders who were eligible for release after completing their prison sentences even before the implementation of the MHA 2007.

Highlighting that the hotly contested changes to the MHA 1983 brought by the MHA 2007 were not necessary to the operation of the DSPD units, several MHRT members "identified that through case law the issue of treatability had become largely redundant" (Trebilcock and Weaver 2010a, p.72). One member further observed that "MHRTs would always take risk into consideration before treatability" (Trebilcock and Weaver 2010a, p.72). For example, one MHRT member observed that it was often easy to

satisfy the test of whether treatment was likely to "prevent deterioration" in the patient's condition, as the fact the patient was in hospital meant that re-offending could be prevented. Thus, the test was malleable enough to allow public protection to be prioritised over the offender's claim to liberty. This, in combination with the *Hutchison Reid* cases, begs the question of whether the much-debated changes to the MHA 1983 were in fact necessary.

The Law Society suggested that the "problem" targeted by the DSPD proposals may not have been a legal problem but rather a problem with the "culture" that determined "the care, treatment and management of people with severe personality disorder" (Law Society 2000). The Society questioned whether changes in the law could be expected to "enforce the required changes in 'culture'" (Law Society 2000). In the event, a combination of political and clinical therapeutic optimism, the development of a range of treatments and greater treatment capacity, and a more flexible approach to the concept of "treatability" by the courts may have contributed to resolving the DSPD problem without the need for legislative intervention. Martyn Pickersgill argues that, over time, personality disorder has come to be seen as "treatable" through "a […] complex series of reciprocal interactions and mutually constitutive processes between clinical knowledge, law and policy" (Pickersgill 2012, p.32). These include the promotion of the notion that personality disorder was treatable by the Department of Health and Home Office and the flowering of a clinical literature on effective treatment approaches. In Pickersgill's view, the DSPD programme also played a role in this process. As clinicians were largely free to develop their own treatment approaches based on a range of different theoretical models, "the DSPD units acted as laboratories within which framings of personality disorder could be experimented with" and "played a salient role in the constitution of the conception that personality disorder was treatable" (Pickersgill 2012, p.42). More concretely, as argued by one interviewee, the DSPD units provided some of the treatment capacity needed to accommodate those in the DSPD category within the hospital system. The achievements of these on-going processes may therefore have been cemented and legitimised by eventual legislative changes rather than prompted by them. However, as argued below, the new test of appropriate treatment leaves room for argument on whether personality disorder is now regarded as "treatable" by the law.

(b) Appropriate medical treatment

A permissive view has been taken in some cases as to what constitutes "appropriate medical treatment" for personality disorder. In *MD v. Nottinghamshire Healthcare NHS Trust* [2010] UKUT 59 (AAC), the Upper Tribunal held that although the applicant, who suffered from psychopathic disorder, was not psychologically able to engage with treatment at the time of the decision, he had "the potential to benefit from the milieu of the ward both for its short term effects and for the possibility that it would break through the defence mechanisms and allow him later to engage in therapy" (*MD*, para. 39). Thus, the Court held that appropriate treatment was available to him. As Bartlett and Sandland (2014) note, this "comes perilously close to finding that detention is, itself, appropriate treatment [and] undercut[s] the therapeutic image which the appropriate treatment test was meant to foster" (Bartlett and Sandland 2014, p. 255).

A more cautious approach was, however, taken in the subsequent case of *DL-H v. Devon Partnership NHS Trust and Secretary of State for Justice* [2010] UKUT 102 (AAC), decided by the same Upper Tribunal judge, Judge Jacobs. The Tribunal was concerned that the definition of "medical treatment" given in s.145 was so broad that there was a "danger that a patient for whom no appropriate treatment is available may be contained for public safety rather than detained for treatment" (*DL-H*, para. 33). In order to avoid this, the judge advised that:

> The tribunal must investigate behind assertions, generalisations and standard phrases. By focusing on specific questions, it will ensure that it makes an individualised assessment for the particular patient. What precisely is the treatment that can be provided? What discernible benefit may it have on this patient? Is that benefit related to the patient's mental disorder or to some unrelated problem? Is the patient truly resistant to engagement? (para. 33).

In the case of *R (SP) v. Secretary of State for Justice* [2010] EWCA Civ 1590, Lady Justice Arden commented that it was not the case that "a person's known rejection of all treatment could never be relevant to the formation by a medical practitioner of his opinion as to the appropriateness of treatment". The implication is that appropriate treatment may be held not to be "available" where the patient is actively resisting all treatment. This indicates that the old problem of patients resisting treatment in the hope of being discharged could resurface under the new test.

The dicta of the Court in *DL-H* and *SP* appear to set a higher standard than that established in *MD* and *Hutchison Reid* and suggest that debate on what constitutes appropriate treatment in the case of personality disorder is on-going. While Pickersgill highlights that the claim that "personality disorder is treatable" has increasingly been made he also notes that not all mental health practitioners are convinced and some scepticism remains (Pickersgill 2012, p.44). The continuing paucity of robust evidence for the clinical effectiveness of treatments, particularly for ASPD, may leave room for argument over whether appropriate treatment is "available" for these patients (see Gibbon *et al.* 2010; Khalifa *et al.* 2010; Stoffers *et al.* 2010; 2012). Furthermore, as discussed in the next section, the issue of "treatability" has crept back into the case law on the choice between a prison sentence and a hospital order for mentally disordered offenders. In this context, it operates as a means of excluding difficult personality disordered offenders from hospitals and pushing them into the criminal justice system.

4. The Choice between Punitive and Therapeutic Disposals

As noted earlier, it is difficult for personality disordered offenders to succeed in raising defences based on mental disorder. This suggests a tendency for the law to treat personality disordered offenders as criminally responsible despite the volitional and emotional deficits associated with their disorders. Prior to the recent case of *Vowles*, a line of case law was developing that took into account various factors in determining the choice between a prison sentence and a hospital disposal for mentally disordered offenders. These included the causal connection between the offender's mental disorder and his offence, the presence of independent factors contributing to offending, and the offender's level of culpability. Following *Vowles* the distinction between offenders with low and high culpability is less important as the CA now prioritises prison disposals and seeks to punish mentally disordered offenders for "any element or particle of responsibility" they have for their offences (Ashworth and Mackay 2015). Nevertheless, the Court's reasoning in the individual appeals grouped within *Vowles* reveals differences between the Court's view of personality disordered offenders and those with mental illnesses alone. Concern for reflecting the culpability of the individual offender and protecting the public continue to influence judicial reasoning and considerations of offender wellbeing come second, if they feature at all.

(a) Sentencing mentally disordered offenders before Vowles

(i) Risk and welfare

In *R. v. Birch* (1989) 11 Cr. App. R. (S.) 202, the CA held that:

> The choice of prison as an alternative to hospital may arise in two quite different ways: (1) If the offender is dangerous and no suitable secure hospital accommodation is available […] [and] (2) Where the sentencer considers that notwithstanding the offender's mental disorder there was an element of culpability in the offence which merits punishment (*Birch,* p.215).

The Court commented that the latter scenario includes "where there is no connection between the mental disorder and the offence, or where the defendant's responsibility for the offence is 'diminished' but not wholly extinguished" (*Birch,* p.215). The dual factors of public protection and punishment highlighted in *Birch* continue to structure the Courts' reasoning in relation to mentally disordered offenders.

The early preference of the CA in sentencing mentally disordered offenders was to impose a hospital order with restrictions under s.37 and s.41 of the MHA 1983. The CA in *Birch* noted that "a hospital order is not a punishment" and therefore considerations of "retribution and deterrence, whether personal or general, are immaterial". Rather, the "sole purpose of the order is to ensure that the offender receives the medical care and attention which he needs in the hope and expectation of course that the result will be to avoid the commission by the offender of further criminal acts." This implies that the presence of a causal connection between the disorder and the offending behaviour counts in favour of a hospital order.

A hospital order may only be made by a Court under s.37 of the MHA 1983 where it is satisfied that "the offender is suffering from mental disorder [...] of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him" (s.37.2(a) MHA 1983). The Court may make the hospital order subject to restrictions under s.41 if this is "necessary for the protection of the public from serious harm".

The Mental Health Tribunal has a duty to discharge a patient detained under a hospital order:

> if it is *not* satisfied: (i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (ii) that it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment; or (iia) that appropriate medical treatment is available for him (s.72(1)(b) MHA 1983. Emphasis added).

When a restriction order has been imposed under s.41 MHA 1983, the patient may not take leave of absence, be transferred to another hospital without the assent of the Secretary of State and may not be discharged from hospital except by the Secretary of State or a Tribunal. When considering discharging a restricted patient, the Tribunal must have regard to the same criteria as for unrestricted patients with the proviso that "if the tribunal is satisfied that it is *not* appropriate for the patient to remain liable to be recalled to hospital for further treatment, they *must* direct an absolute discharge" (s.73(1)(b) MHA 1983. Emphasis added).

In *Birch*, following the case of *R. v. Howell* (1985) 7 Cr. App. R. (S.) 360, the CA held that "in the absence of any question of culpability and punishment, the judge should not impose a sentence of imprisonment simply to ensure that if the [Mental Health] Review Tribunal […] is […] constrained to order a discharge, the offender will return to prison rather than be set free" (*Birch*, p.215). Thus, the Court did not support the use of prison sentences as a means of managing the risks presented by mentally disordered offenders. It also held, following *R. v. Mbatha* (1985) 7 Cr. App. R. (S) 373, that "even where there is culpability, the right way to deal with a dangerous and disordered person is to make an order under section 37 and 41". This indicates that the Court prioritised the medical management of mentally disordered offenders over their punishment.

The decision of the House of Lords (HL) in *R. v. Drew* [2003] 1 W.L.R. 1213 seemed to deviate from the therapeutic approach taken in *Birch* and moved towards a more risk-averse stance. The HL noted that "defendants made subject to hospital orders, whether restricted or not, are entitled to release when the medical conditions justifying their original admission cease to be met" and, thereafter, "are liable to recall only on medical grounds". The Court remarked that such defendants may, however, "be a source of danger to the public even though these medical conditions are not met" (*Drew*, para. 21). A defendant sentenced to life imprisonment, on the other hand, could not be

released unless the Parole Board was satisfied that it was safe to do so and he could be recalled to prison if "he appear[ed] to present a danger to the public" (*Drew*, para. 21). "In short", the court concluded, "an automatic life sentence affords a measure of control not available under the other available orders" (*Drew*, para. 21).

The HL noted the suggestion made on behalf of the Home Secretary that cases including *Howell* and *Mbatha*, "gave less than adequate weight to the differing conditions governing the release and recall of restricted patients as opposed to life sentence prisoners". It went on to hold that these were "a matter to which sentencing judges and appellate courts should try to give appropriate weight". However, the "notorious" "difficulties caused to prison managements by the presence and behaviour of those who are subject to serious mental disorder" meant that the Court "would need to be persuaded that any significant change in the prevailing practice was desirable" (*Drew*, para. 22). The HL in *Drew* regretted, however, that the s.45A hospital and limitation direction was only available at the time for offenders suffering from psychopathic disorder. In the Court's view, such an order would have provided a useful means for ensuring an offender received treatment for his mental disorder in hospital.

Hospital and limitation directions were introduced by the Crime (Sentences) Act 1997. A hospital direction, placing the offender in a specific hospital, and a limitation direction, subjecting him to restrictions, may be attached by the Crown Court to a custodial sentence and the criteria are the same as for a hospital order. Originally, s.45A orders were available only for offenders in the psychopathic disorder category. Following the introduction of the MHA 2007 they are now available for convicted offenders with any mental disorder. The measure originated in the "hybrid order" originally recommended for psychopaths of uncertain treatability by the Reed (1994) working group. In 1996, a different version of the Reed proposal appeared in a joint discussion paper issued by the Home Office and Department of Health (1996). This dropped the emphasis on "uncertain treatability" and instead "stressed that the existing hospital and restriction orders were 'insufficiently flexible' where the courts were not certain that 'treatment will sufficiently address the risk to the public' or where they believed that 'a punitive element in the disposal is required to reflect the offender's whole or partial responsibility'" (Eastman and Peay 1998, p. 96, citing Home Office and Department of Health 1996, para. 1.4). By 1997, the emphasis had shifted, moving

away from the idea of partial responsibility and again stressing public protection (Home Office 1997, cited in Eastman and Peay 1998, p. 97).

A patient subject to a hospital and limitation direction may only be discharged from hospital before the end of his prison sentence by the Secretary of State, who may order his transfer to prison. The patient's Responsible Clinician can propose to the Secretary of State that the patient be transferred to prison at any point before the expiry of his sentence if "no further treatment is necessary or likely to be effective" (MHA 1983 Code of Practice, para. 33.23). The limitation direction ceases to have effect upon the expiry of the offender's prison sentence, but the hospital order continues in force so that he may be detained in hospital as if on a non-restricted hospital order (Rutherford 2010, p. 33). If the prisoner has been given an indeterminate sentence his release will be at the discretion of the Parole Board, who will decide on public protection rather than medical grounds.

The judicial preference for public protection over the therapeutic needs of the offender was made more explicit in the case of *R. v. Staines* [2006] EWCA Crim 15. In that case, the defendant appealed against a discretionary life sentence and s.45A order imposed after she pleaded guilty to manslaughter by reason of diminished responsibility. The sentencing judge had held that this disposal was appropriate on the grounds of the seriousness of the appellant's offence, her record of previous violence and the "considerable risk of serious danger" she posed to the public. Psychiatrists at Staines's sentencing hearing had argued against a hospital order with restrictions because her diagnosis was primarily one of BPD or psychopathy and there was a danger she would be released by a Tribunal if she resisted treatment or was found to be "untreatable" under the former MHA 1983. One psychiatrist argued that a prison sentence plus a s.45A order "would carry with it the safety net that [Staines] could be returned to prison should she refuse to engage in treatment or should the treatment be unsuccessful, thereby ensuring the protection of the public whilst at the same time giving the opportunity for treatment to be attempted" (*Staines*, para. 8).

Three and a half years later, Staines appealed against her sentence. Her counsel argued that, in the interim, she had proven treatable and was suffering from mental illness in addition to psychopathic disorder. A restricted hospital order was therefore the appropriate sentence. Her counsel further argued that the s.45A would encourage

Staines to resist treatment in hospital when engagement with therapy became too difficult in order to engineer a transfer to prison. Such a transfer would have been detrimental to her mental state. Counsel for the appellant also suggested that a Mental Health Review Tribunal would be better placed than the Parole Board to "impose more pertinent conditions" on her release from custody and to "ensure a more relevant support and monitoring regime" (*Staines*, para. 26).

The CA rejected these arguments in a judgment that prioritised the protection of the public over the therapeutic needs of the appellant. The Court concluded that there was no "realistic possibility" that Staines would be returned to prison "at the conclusion of successful treatment" (*Staines*, para. 28). Rather, it found that her treating team would have a choice between recommending to the Parole Board that she be returned to prison or discharged from hospital into the community "through the usual range of medium secure and then less secure accommodation" (*Staines*, para. 29). Following this, the Court could "see no reason" why the Parole Board could not make "appropriate arrangements" for the appellant's release. It therefore found no reason to disturb her sentence.

In the subsequent case of *R. v. Cooper* [2010] EWCA Crim 2335, the CA not only prioritised the protection of the public over the wellbeing of the offender but also over that of prison staff and other prisoners. In *Cooper*, counsel for the appellant argued that the "pitfall" of a life sentence and hybrid order was that once a Mental Health Tribunal found the appellant no longer suffered from mental illness, his rehabilitation could be "thwarted" by the Parole Board's concern for public protection. The result, "in all probability, would be a transfer back to a prison and a heightened risk of relapse with a significant danger to staff and prisoners within the prison setting, before a transfer back to hospital might be [effected]" (*Cooper*, para. 18). The CA dismissed this point on the basis that "if the appellant's therapeutic rehabilitation were to be so fragile that a prison setting, however structured to deal with one who had suffered serious mental disorder, might cause it to re-emerge […] [it] would be very concerned about the potential pitfalls he would face if he had been discharged back immediately into the community" (*Cooper*, para. 18).

Perhaps disingenuously, the CA in both *Cooper* and *Staines* argued that the Parole Board could negotiate a package of social and psychiatric support for the respective appellants' release. By this, the decisions imply that the Parole Board could act like a Tribunal in

ensuring an individual's mental health needs were met but that a Tribunal could not be trusted to protect the public as effectively as the Parole Board. The Court also appears to expect the hospital system to act like the prison system and continue to detain patients whose disorders have been successfully treated and allow them to progress downwards through security categories towards release. The judgments are dismissive of the prospect that the appellants would be transferred to prison once they recovered or where all treatment options had been exhausted. As noted previously, this was the original purpose of the hybrid order. The judgments also dismiss the point that the prison environment can be highly stressful and prisons are poorly equipped to care for vulnerable individuals whose mental conditions may deteriorate following transfer. In *Cooper*, the Court seems to expect the Tribunal and Parole Board to work together to make special provisions for the appellant without citing any evidence that this is possible or making any arrangements to ensure it has been done. The judgments therefore leave a great deal to administrative discretion in ensuring appropriate care is given to mentally disordered prisoners.

The CA in *R. v. Welsh* [2011] 2 Cr. App. R. (S.) 68 continued this trend towards prioritising public protection. The CA held it was "bound to take into account" the question of "public confidence […] when choosing between a hospital order with restriction and life imprisonment" and that this could "only be satisfied by ensuring that the issue is resolved in a way which best protects the public and reflects the gravity of the offence" (*Welsh*, para. 14). In that case, given the appellant's "propensity for violence", which pre-dated his paranoid schizophrenia and the seriousness of his offending, the CA did not accept that a hospital order with restrictions would maintain public confidence. Furthermore, the Court considered that "there [was] a risk he [would] remain a source of danger even if his condition substantially improves once he has received treatment and medication" (*Welsh*, para. 17). The Court left the appellant's discretionary life sentence in place so that he could not be released unless the Parole Board was satisfied "that it was no longer necessary for the protection of the public that the prisoner should be confined" (*Welsh*, para. 15, citing s.28(6)(b) (Crime (Sentences) Act 1997).

Welsh illustrates the difficulties facing courts responsible for sentencing a mentally disordered offender who is in need of hospitalisation but who is also likely to continue to pose a risk to the public even after his mental disorder has successfully been treated.

The test followed in subsequent cases of this nature was laid down in in *Attorney General's Reference No 54 of 2011* [2011] EWCA Crim 2276. The CA noted in that case that the defendant's risk of reoffending arose partly from the criminal lifestyle he was leading prior to the emergence of schizophrenia. Consequently, it was concerned that he could be released from hospital by a Tribunal once his mental disorder had been treated even if he remained a danger to the public. While the CA acknowledged it "was not in the defendant's interests but much more importantly it was not in the public's interest that his apparent recovery [in hospital] should be put in jeopardy" it felt that a hospital order had been the incorrect choice (*AG's Reference*, para. 16). The Court recognised there was a "tension" between the risk raised in psychiatric evidence that a transfer to prison would foster the applicant's incipient antisocial personality traits on the one hand and "a complete absence of control on licence on the other". In the circumstances, however, it felt that "the risk [had] to be taken" (*AG's Reference*, para. 19). The Court achieved the desired effect by passing an order of Detention for Public Protection (DPP) and making arrangements for the appellant to be transferred directly from court to hospital under s.47.

The case of *R. v. Fort* [2013] EWCA Crim 2332 is in many ways the converse of *AG's Reference*. The appellant had no previous convictions, his crime (killing his mother) appeared senseless and there was psychiatric evidence that his actions were caused by a dissociative state provoked by possible schizophrenia. The CA, applying the test in *AG's Reference*, found that the appellant's risk of further serious offending would no longer be significant once his mental disorder had been treated. The Court therefore quashed his life sentence and the s.45A order and substituted a hospital order with restrictions. Similarly, in *R. v. Ruby* [2013] EWCA Crim 1653, the CA found that "although the applicant was dangerous, his explosion of violence was the product of his mental disorder, which was susceptible to treatment" and he had no previous convictions (*Ruby*, para. 35). The CA therefore chose to substitute a hospital order with restrictions.

In *Ruby* and *Fort*, the psychiatric evidence raised concerns that the appellants' treatment would be jeopardised by a transfer to prison but these arguments were not directly addressed by the CA. Instead, the Court decided both cases on the grounds the appellants would not pose a serious risk to the public if discharged by a Tribunal. As Jill

Peay (2015) points out, the comment of one psychiatrist at Ruby's trial that the Parole Board would have difficulty in assessing the risks posed by a prisoner with Asperger's syndrome and personality disorder may also have influenced the CA's decision to make the appellant subject to monitoring by the Tribunal and Secretary of State. This would be in line with the Court's concern for managing risk.

A clear trend towards prison disposals for offenders who present a risk of reoffending independent from their disorders may be discerned from the cases discussed here. This is the case even where the wellbeing of the individual, and of those around him, is clearly jeopardized by the prospect of a transfer to prison. The case law thus demonstrates that a concern for protecting the public takes priority over attending to the welfare of the offender. The reference in *Welsh* to the need to ensure "public confidence" in sentencing is telling, as the symbolic nature of efforts to reassure the public may be just as important as avoiding actual harm. Preventive measures may be motivated by a pragmatic effort on behalf of the state to avert future moral outrages and avoid blame (see Wolff 2006). This may be seen in the CA's concern in *Welsh* to ensure "public confidence" in the sentencing of serious offenders and in the emphasis in *Vowles* on punishing culpable mentally disordered offenders, considered later. The perceived causal connection between the disorder and risk of offending also influences the court's view of the culpability of the offender, considered in the next section.

(ii) Culpability

As noted in *Birch*, the decision to impose a prison sentence on a mentally disordered offender (with or without an order under s.45A) is also intended to reflect his culpability. Several cases involving appeals against hybrid orders refer to the concept of "partial culpability" which originally derived from the defence of diminished responsibility. Curiously, this concept has been transposed into non-homicide cases in which a plea of diminished responsibility is not available. According to Peay, the "fluid[ity]" of the concept of partial culpability has generated "some incoherence" in the case law as "some offenders with partial culpability are sent direct to hospital; and others given the perceived safety-net of the s.45A" (Peay 2015, p. 39).

The defendants in *Fort* and *Ruby*, considered previously, had not been found insane or unfit to plead and, therefore, must have borne some responsibility for their offences.

Restricted hospital orders were nonetheless judged to be a suitable disposal. The issue of Ruby's culpability was not discussed at all, whereas the Court in *Fort* found the appellant "did not have much, if any, mental responsibility for his actions" (*Fort*, para. 54). A plea of insanity was not open to Fort despite his almost total lack of responsibility. However, a non-punitive hospital order with restrictions allowed the Court to do justice in his case. This may be seen as an example of how courts "work round" the problems presented by the narrowness of the insanity defence (Law Commission 2013, para. 1.10). Thus, in the earlier case law, a hospital order with restrictions emerged as a solution for defendants whose culpability was very low or absent but who did not satisfy the narrow criteria for unfitness to plead or insanity.

By contrast, in *Drew*, while the HL accepted it was "wrong in principle" to punish defendants who are unfit to plead or insane, it noted that the appellant had "pleaded guilty to an offence of which an essential ingredient was an intention to cause [GBH] to another" (*Drew*, para. 16). The Court concluded that "the appellant's mental illness could properly be relied on as mitigating the criminality of his conduct but not as absolving him from all responsibility for it" (*Drew*, para. 16). Similarly, in *Staines*, the judge stated that, while the appellant's plea of diminished responsibility had been accepted, her responsibility for the killing was reduced but not extinguished. Like the appellant in *Drew*, Staines had not been found unfit to plead or insane at her trial and the judge concluded that she bore "a considerable degree of responsibility" for the "savage killing" she had carried out (*Staines*, para. 9).

In *Cooper* there was psychiatric evidence that the offences would not have occurred but for the appellant's mental illness and the link between his disorder and offending was therefore strong. However, there was also evidence of "aggressive and abusive" elements to his personality and that he would continue to present a risk after treatment. Furthermore, taking into account psychiatric evidence that it was likely the appellant's drug abuse had contributed to his psychosis, the CA approved the trial judge's finding that he had "voluntarily embarked upon the course of events which led to his illness" and therefore "must bear some responsibility" for his offence. As Peay suggests, it seems here that the Court was "casting around for a basis to attribute responsibility in the context of what was clearly an acute psychotic episode, however brought about" (Peay 2015, p.25). By attributing blame to the defendant for triggering the psychiatric symptoms that prevented him from exercising his will, the Court found a basis for punishing a defendant

whose culpability was otherwise low but who presented an independent risk of re-offending.

Similarly, in *R. v. Fox* [2011] EWCA Crim 3299, the trial judge considered that while the appellant's culpability was "reduced" by his mental disorder it was "not wholly excluded". In support of this finding, the judge relied on the fact that the jury had found Fox guilty of a crime that required a *mens rea* of intention, that the alcohol he had voluntarily consumed meant his ability to resist a voice that had told him to hurt the victim was reduced, and that he had been able "to take deliberate measures" to escape the scene of the crime. The CA approved this reasoning and concluded that the appellant's "will was not entirely overborne by the voices in his mind". There was also evidence that the appellant had a tendency to react impulsively and violently to feelings of anger and jealousy and had difficulties controlling his anger likely to be exacerbated when in a psychotic state. The CA left in place the two IPP sentences with eight year tariffs set by the judge who, in the Court's view, had taken into account the mitigating circumstances of the defendant's mental disorder and had "rightly" determined that such a minimum term would ensure an "appropriate degree of punishment".

The derivation of culpability from a guilty plea to an offence requiring a *mens rea* of intent is problematic. As noted previously, the deficiencies of the current test for unfitness to plead raise the possibility that the pleas of personality disordered offenders may in some cases be attributable to their disorders. As Peay argues, in cases such as *Fox* and *Cooper*, the fact that the offenders were acutely psychotic at the time their offences "brings into question the extent to which [they] truly appreciated the consequences of their pleas" (Peay 2015, p.39). Furthermore, the fact that a defendant pleads guilty to an offence does not mean that intent has been proven, particularly given that defendants have an incentive to plead guilty in order to receive mitigation of sentence. The narrowness of the insanity defence and its focus on cognitive rather than volitional, moral or emotional capacities also casts doubt on the finding that defendants retained culpability for their offences simply because they did not raise or were unable to prove insanity.

Although *AG's Reference* had not yet been decided, the fact that the appellants in *Cooper* and *Fox* had previously demonstrated aggressive and violent or abusive tendencies before the onset of their illnesses is likely to have been a factor in the Courts' decisions to impose

a prison sentence in order to ensure public protection. The combination of the two elements in *Birch* coupled with the limited availability of the insanity defence may thus explain some of the "incoherence" noted by Peay (2015). In cases such as *Cooper* and *Fox* in which the causal connection between the mental disorder and offending was strong but the defendant posed a risk of reoffending independent of his mental disorder, a prison sentence was passed to ensure risk was adequately managed and to reflect the offender's residual culpability. In cases such as *Fort* and *Ruby*, on the other hand, the causal connection was strong and culpability was low but the defendant did not pose a risk independent of his mental disorder. A hospital order was therefore the correct choice.

A punitive sentence may also have some symbolic importance. In the case of *R. v. Poole* [2014] EWCA Crim 1641, the CA left in place the appellant's determinate sentence as this was intended by the sentencing judge to reflect Poole's "culpability". This was despite the fact that Poole was likely to spend the whole of his determinate prison sentence in hospital and a transfer to prison was judged not to be appropriate. There must therefore have been something symbolic in the handing down of a prison sentence to a "partially culpable" defendant that would not be achieved by a non-punitive hospital order with restrictions. The defendant in Poole was convicted of offences of dishonesty, demonstrating that the notion of "partial culpability" has been extended to cases in which diminished responsibility was not an available defence. The concept of partial culpability continues to be relevant following the recent decision of the CA in *Vowles*, considered below.

(b) Sentencing Mentally Disordered Offenders after Vowles

(i) New guidelines

The recent case of *Vowles* consummates the CA's retreat from the more therapeutic position it adopted in the earlier cases of *Birch, Mbatha* and *Howell*. The judgment is intended to provide definitive guidance to courts sentencing mentally disordered offenders. The CA in *Vowles* distinguished the HL's reluctance in *Drew* to recommend a change in sentencing practice and asserted that "the release regime that will apply to the offender" is now of "primary importance" in the choice between a restricted hospital order and an indeterminate sentence (*Vowles*, para. 12; para. 52).

As Andrew Ashworth and Ronnie Mackay (2015) observe, two principle themes emerge from *Vowles*. First, courts "should ensure that a mentally disordered offender is punished for any element or particle of responsibility for her or his wrongdoing". Second, they should "focus on finding the sentence or disposal with the most suitable release provisions, taking account of the risk presented by [the defendant]" (Ashworth and Mackay 2015, p. 545). Thus, in line with the trend noted in earlier cases, sentencing decisions following *Vowles* are to be structured by considerations of public protection and punishment rather than by the prospect of therapeutic benefit to the patient.

In seeming deviation from the earlier cases, however, the judgment also makes clear that a prison sentence, with or without an order under s.45A, is now the default option for all mentally disordered offenders. Judges are now required to give "sound reasons for departing from the usual course" (*Vowles*, para. 51). Nevertheless, the decisions of the CA in the individual appeal cases it considered seem to show that the nature of the defendant's mental disorder, the causal connection between the disorder and the offending, and the "treatability" of the disorder will continue to be relevant to the choice between a prison sentence and a hospital order.

According to the Court in *Vowles*, in cases in which the criteria for a hospital order in s.37(2)(a) are met, judges must "carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions". This seems to indicate that the Court has become sceptical of psychiatric evidence and places greater emphasis on judicial expertise. This marks a further departure from the therapeutic approach of earlier cases such as *Birch* and increasing concern for ensuring public protection and punishment. Thus, in considering the appropriate disposal, "the matters to which a judge will invariably have to have regard" include:

> (1) the extent to which the offender needs treatment for [mental disorder] […]; (2) the extent to which the offending is attributable to the mental disorder; (3) the extent to which punishment is required; and (4) the protection of the public including the regime for deciding release and the regime after release. (*Vowles*, para. 51)

Reflecting the case law outlined previously, the CA noted that a hospital order with restrictions "is likely to be the correct disposal" "if: (1) the mental disorder is treatable;

(2) once treated there is no evidence [the offender] would be in any way dangerous; and (3) the offending is entirely due to that mental disorder" (*Vowles*, para. 54 (iii)). The court "must", however, "also have regard to the question of whether other methods of dealing with [the offender] are available" and this includes whether transfer to hospital under s.47 would "taking into account all the other circumstances, be appropriate" (*Vowles*, para. 54 (iv)).

There appears to be a conflict between these directions and the order in which the CA now advises sentencing courts to approach the choice between a prison sentence and a hospital order. The guidance states:

> A court should, in a cases where: (1) the evidence of medical practitioners suggests that the offender is suffering from a mental disorder; (2) that the offending is wholly or in significant part attributable to that disorder; and (3) treatment is available, and it considers in the light of all the circumstances, that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case, […] [first] consider whether the mental disorder can appropriately be dealt with by a hospital and limitation direction under s.45A (*Vowles*, para. 54).

As mentioned previously, the criteria for the imposition of a hospital order and a hospital and limitation direction under the MHA 1983 are the same. Consequently, if a sentencing court first considers imposing a prison sentence and a hospital and limitation direction and finds the relevant criteria are fulfilled it is likely to choose this option, negating the need to then consider making a hospital order. Furthermore, the CA's guidance seems to run counter to s.45(1) of the MHA 1983, which states that a hospital and limitation direction applies where the criteria for its imposition are fulfilled, and where "the court considers making a hospital order in respect of [the defendant] *before* deciding to impose a sentence of imprisonment" (emphasis added). This implies that sentencing judges should *first* consider making a hospital order before passing a prison sentence coupled with a hospital and limitation direction under s.45A.

As Ashworth and Mackay (2015, p.547-8) argue, the Court in *Vowles* clearly "ignores s.45A(1)(b), reverses the statutory priority of the order and fails to insist that hospital and limitation directions should be received for offenders who pose a serious risk to the public and merit punishment as a result of a high degree of culpability". The CA in

Vowles also appears to recommend a prison sentence and s.45A order in cases in which the offending is wholly attributable to mental disorder and culpability is therefore low or absent. On this interpretation, "the traditional notion of the s.45A order as providing an option for treatment in cases of high culpability and high risk would be all but extinguished" (Peay 2016, p.159). However, it will be argued below that the court's reasoning in the six separate appeals it considered implies that a hospital order with restrictions is the correct choice where the casual connection between the appellant's disorder and his offending is strong and the disorder is treatable.

(ii) The individual appeals in Vowles

All six appellants in *Vowles* were serving discretionary life or IPP sentences and had been transferred from prison to hospital by the Secretary of State exercising his power under s.47 MHA 1983. All sought to have their sentences quashed and substituted for hospital orders with restrictions. The Court did so in three cases but left the sentences in place for the other three. Following its own guidance, however, the Court may have been expected to hand down prison sentences with hospital and limitation directions attached in all six cases, or to leave the prison sentences in place as the appellants were already detained in hospital under s.47.

Although therapeutic considerations were raised in argument, public protection and the question of culpability appeared to be the determining factors in the three successful appeals. At the time the appellants in *Coleman*, *Odiowei* and *McDougall* were sentenced they were thought to be suffering from personality disorders and were sent to prison. Following their transfer to hospital, however, they were each eventually diagnosed with schizophrenia and were responding to treatment. In *Coleman*, the Court quashed the appellant's sentence on the grounds of "the nature of her mental disorder" (schizophrenia), "its causal connection with [her index offence], its treatability and the clear evidence that her condition will be better managed on release under the MHA regime and the public better protected" (*Vowles*, para. 133). Similar reasoning applied in the other two cases. The Court also commented that a hospital order with restrictions under s.37 and s.41 was more likely to be appropriate for defendants primarily diagnosed with "severe mental illness" than for those with personality disorder. The Court explained this distinction on the grounds that it was "more likely" that severe mental illness would "have a direct bearing on the offender's culpability" and that it was

"likely to be more responsive to treatment in a hospital". The decisions indicate that a strong causal connection between the individual's disorder and his offending implies low culpability and militates in favour of a hospital disposal. Where the causal connection is strong and the disorder is treatable in hospital this also weighs in favour of release by the Tribunal rather than by the Parole Board.

The decision in the three successful appeals may be contrasted with the Court's decision in the leading case of *Vowles*. In that case, the Court focused on the culpability of the appellant, who was diagnosed with BPD. The Court held that it was appropriate to leave her IPP sentence in place, "taking into account the nature of her mental disorder", "her culpability for the offence, the need for punishment and the risk to the public" (*Vowles* para. 98). In the case of *Barnes*, on the other hand, the Court focused on the causal connection between the appellant's mental disorder and his offending rather than on his culpability. The Court found that it was "evident that Barnes had a serious criminal record; he was a heroin addict and this played a significant part in his offending". Furthermore, the Court was of the view that it "[could not] be said that the [appellant's] personality disorder and his learning disability as distinct from his drug addiction were the driving factors at the time [of the offence]". Given the lack of a clear causal connection between the appellant's mental disorder and his offending, therefore, the Court considered that a hospital order would not have been appropriate and left his prison sentence in place.

In the final appeal of *Irving*, the Court concluded that while there was "no doubt" the appellant was "rightly placed […] within the hospital system rather than in a prison environment" this did not mean that a prison sentence had been the wrong choice. In seeming criticism of the psychiatric experts in the case, the Court stated that "the fact of mental illness […] is not a passport to a medical disposal as many of the psychiatric opinions we have considered […] appear to presume" (*Vowles*, para.196). Rather than merely following the recommendations of psychiatric experts, the Court held that "the sentencing judge must have regard to 'all the circumstances, including nature of offence, character and antecedents and the other available means of dealing with [a defendant]' and thereafter only make a hospital order if it is the 'most suitable method of disposal'" (*Irving* para. 196, quoting s.37(2) MHA 1983). While "a causal link between a defendant's mental disorder and the offences" was not necessary for a s.37 hospital order or s.45A hybrid order to be made, "it remain[ed] a legitimate factor to

weigh in the balance of the circumstances as a whole" (*Vowles*, para.197). The Court concluded that fresh psychiatric evidence that the appellant's learning disability had been underestimated in pre-sentence reports had not "established any sufficient causal link which would tend to support the argument that the first instance judge was wrong in principle to impose a prison sentence rather than a hospital order". This implies that where the causal link is strong enough, this would militate in favour of a hospital order rather than a prison sentence.

Despite the Court's reasoning in the three successful appeals, the CA's guidance in *Vowles* may be predicted to result in prison sentences being handed down to offenders not otherwise deserving of punishment. Such individuals may be expected to spend most, if not all, of their prison sentences in hospital. However, if their disorders are successfully treated or prove untreatable they may be transferred to prison to finish out their sentences if the criteria for their detention in hospital are no longer fulfilled. As highlighted by Jill Peay, this may be expected to give rise to "the difficulties caused to prison managements by the presence and behaviour of those who are subject to serious mental disorder" the HL warned against in *Drew* (para. 22) "albeit not immediately" (Peay 2016, p.159). It should also be noted that the Court in the successful appeal cases also found that the mental health route would be a better means of ensuring the public was protected from offenders whose mental illnesses were causally connected to their disorders. The Court's own guidance would appear to thwart this rationale, however, as the Parole Board is responsible for release decisions in relation to offenders serving indeterminate sentences.

According to Peay (2016), following its own guidance, the CA in *Vowles* may well have imposed prison sentences in the three unsuccessful appeals, leaving the Secretary of State to exercise his power under s.47. However, as the Court used *Vowles* as the leading case, it must have considered that particular appellant to be a suitable candidate for an order under s.45A had one been available at the time she was sentenced (Peay 2016). The choice between s.45A and s.47 in the case of defendants such as Vowles, who retain a greater measure of culpability, and defendants such as Irving and Barnes, whose disorders are not causally connected to their offending, may be structured by practical considerations rather than by any clear principles. Hospital and limitation directions may be used for those who require immediate transfer to hospital. For those less clearly in need of treatment in hospital, a prison sentence may be passed, leaving

the Secretary of State to exercise his power under s.47 to direct transfer to hospital. Perhaps by reversing the statutory order, the Court merely intended to prompt sentencing courts to make greater use of s.45A. The CA noted, perhaps with some frustration, that s.45A continued to be underused despite the Court's previous guidance on when such orders were appropriate. The CA may not have fully appreciated the effect of its own guidance, however, given that it decided the appeals before it using the principles of causality, culpability and treatability employed in previous cases.

A further question arises as to how cases like the appeals in *Vowles* will be decided following the abolition of the IPP sentence. Four of the appellants in *Vowles* had been given IPP sentences with tariffs of between 18 and 28 months under the former CJA 2003 while two, Odiowei and Irving, had been given discretionary life sentences with tariffs of four and six years respectively. Where a mentally disordered defendant falls into the "gap" left by LASPO 2012, courts may choose to expand the use of the discretionary life sentence or pass an extended determinate sentence, leaving the Secretary of State to exercise his power under s.47 should the defendant require treatment in hospital. In the latter case, increased use of the s.47 power to transfer prisoners to hospital for preventive detention may also be expected as offenders approach the end of determinate prison sentences. The question of late transfers is discussed below.

(c) Sentencing personality disordered offenders after Vowles

(i) Punishment and culpability

The early admission criteria for the DSPD programme called for a "link" between the individual's disorder and his risk of serious offending (DSPD Programme *et al.* 2008a, p.2). Duggan and Howard (2009) concluded that this link was intended to be causal. Early on, the causal link was intended to be a means of selecting out those personality disordered offenders whose offending was attributable to their mental disorders and who could therefore be treated and released when they no longer presented a danger. In reality, however, the causal relationship between personality disorder and offending is unclear and subject to confounding factors. Consequently, the treatment of personality disorder may not lead straightforwardly to a reduction in offending (Duggan and Howard 2009). Furthermore, as the diagnoses of ASPD and psychopathy are

notoriously circular it is difficult to distinguish disordered offending from more normal criminality.

As courts are reliant on psychiatric evidence to demonstrate a causal link between the defendant's mental disorder and his risk of reoffending, the uncertainty of the relationship between personality disorder and serious offending and the paucity of evidence for effective treatment may encourage judges to impose a prison sentence to ensure the public is adequately protected and the defendant is punished. Relying on the psychiatric evidence before it, the CA in *Vowles* expressly stated that while mental illness may be expected to "have a direct bearing on the offender's culpability" it is "more difficult to attribute a reduction in culpability to a personality disorder" (*Vowles*, para. 50 (iii)). Thus, the personality disordered offender is deprived of the benefit of the doubt surrounding the causal connection and more likely to be regarded as deserving of a punitive response. In this context, the "partial" culpability of a defendant who is not able to resist his impulses is a reason to punish him rather than a plea in mitigation of sentence.

The prioritisation of prison sentences with s.45A orders attached has the clear potential to be anti-therapeutic in the case of personality disordered offenders and may be expected to have an adverse impact on their wellbeing. In particular, it runs the risk highlighted in *Staines* that patients who lack motivation to change may resist treatment in the hope of securing a transfer to prison in order to escape the demands of treatment in hospital. This is a possibility that is left open following the interpretation of the "appropriate medical treatment" test in *SP* and *DL-H* in which it was suggested that treatment may not be "available" to a patient who was resisting all treatment. On the other hand, the background threat of imprisonment may jeopardise treatment effectiveness where the patient knows they are likely to be transferred to prison once their mental disorder improves to the extent that their detention in hospital is no longer warranted. There may therefore be a perverse incentive for patients to disengage with treatment in order to remain in hospital rather than face the harsher conditions of prison.

The threat of coercion hanging over patients with prison sentences left to serve may also jeopardise the effectiveness of psychological treatments that require voluntary engagement and motivation to change. The CA in *Vowles* and the judgments in preceding cases pay insufficient attention to the risks posed to mentally disordered

offenders by imprisonment. Furthermore, in a coercive context in which offenders feel pressured into accepting treatment, such interventions may have punitive rather than therapeutic effects. This argument will be developed further in the final substantive chapter of this thesis.

(ii) "Treatability" and risk aversion

The uncertain treatability of personality disorder also prompted a risk-averse response from the CA in *Vowles*. Echoing the long-standing problems noted in Chapter 2 of this thesis, the Court in *Vowles* noted evidence that psychiatrists were concerned they would become "stuck" with personality disordered patients who had proven untreatable but who nevertheless could not be released from hospital due to the risks they posed to the public (*Vowles*, para. 50 (v)). The Court also noted that "at present individuals with severe personality disorders are less likely to benefit from hospitalisation" but that treatment was available "in a range of specialist prisons" (*Vowles*, para. 50 (iii) and (v)). Now there is a greater availability of treatment options in prisons following the DSPD experiment, the CA clearly favours prison disposals for personality disordered offenders. This is despite the similarities between the treatments offered by prison and hospital DSPD units and the continuing debate surrounding whether prison or hospital is the right place for personality disordered offenders reflected in Chapter 3.

The distrust of Mental Health Tribunals evinced in *Vowles* and previous cases may also be misplaced. In the case of restricted patients, absolute discharges without prior conditional discharge are rare – ranging between 15 in 2011 and 5 in 2014 (Ministry of Justice 2016a, Table 8). At between 7% and 9.5%, the percentage of restricted patients discharged conditionally into the community by tribunals has remained low and relatively stable since the mid-1990s (Boyd-Caine 2010, Table 6.2; Ministry of Justice 2016a, Table 8). The MEMOS study demonstrates that risk aversion also influences decisions pertaining to the release of patients in the DSPD category. MHRT members reported that they "were concerned not only about the risks of DSPD patients to themselves or others, but also sensitive of the risks to the credibility of MHRT decision-making" (Trebilcock and Weaver 2010a, p.70). Several members also noted that "the MHRT (and other key decision-makers in the mental health system […]) had become increasingly risk averse" (Trebilcock and Weaver 2010a, p.70).

By contrast to Parole Board members, who described DSPD prisoners "as little different to other high security prisoners", MHRT members saw DSPD patients and others detained under the category of psychopathic disorder as "fundamentally different to other patients in the mental health system" (Trebilcock and Weaver 2010a, p.66). Several MHRT members "appeared to associate personality disorder primarily with offending rather than illness" and one suggested that prison was the appropriate place for these patients (Trebilcock and Weaver 2010a, p.66-7). Strikingly, some members "appeared to regard the likelihood of reoffending by DSPD patients to be high, almost inevitable" (Trebilcock and Weaver 2010a, p.67). While others were more optimistic about the potential for change, several of those interviewed as part of the MEMOS study were "concerned about the lack of evidence base" and "sceptical about the likely benefits of DSPD treatment" (Trebilcock and Weaver 2010a, p.68). Despite these reservations, some "suggested that until patients had engaged with and completed treatment, they were unlikely to be considered by the MHRT for a progressive move" (Trebilcock and Weaver 2010a, p.76). Similarly to high security prisoners, discharge directly into the community from a secure hospital was rare and patients were expected "to undertake a journey through the different levels of security" (Trebilcock and Weaver 2010a, p.65). As in the criminal justice system, personality disordered patients in the mental health system are expected to engage with treatment before they will be allowed to progress. This is despite MHRT members themselves entertaining doubts about the effectiveness of interventions with personality disordered patients.

The personality disorder Catch-22 identified in the previous chapter was also a complicating factor in decision-making for the MHRT. Patients with personality disorder were considered "to be particularly manipulative and skilled at convincing professionals that they are ready for discharge" only to reoffend upon release (Trebilcock and Weaver 2010a, p.70). Like Parole Board members, MHRT members were concerned that the high security, surveillance and staffing levels of the DSPD units meant that the patients' progress in treatment was not being adequately tested. They were also concerned that improvements in patients' behaviour could be attributed to the tightly controlled environment of the DSPD units rather than to changes in the patient (Trebilcock and Weaver 2010a, p.71). As noted in the previous chapter, a level of risk is inherent in the rehabilitation and re-socialisation of offenders as their ability to cope in lower levels of security needs to be tested out. The reluctance of the prisons and

hospitals to take such risks also demonstrates that public protection ultimately takes priority over the rehabilitation of the offender.

Notably, the rules articulated in *Vowles* appear to allow offenders with personality disorder to be excluded from hospital disposals on the basis of a narrow conception of their "treatability" despite the reforms introduced by the MHA 2007. However, as will be considered in the next section, when personality disordered prisoners who are considered to be dangerous can no longer be detained in prison, their "treatability" is construed more broadly in order to facilitate their transfer to and detention in hospital. In this sense, the notion of "untreatability" is used to deny offenders with personality disorder entry to hospital through the front door, even where detention in prison carries the risk of relapse, goes against the individual's therapeutic interests and increases the risk of violence towards staff and other prisoners. On the other hand, the availability of "appropriate medical treatment" is construed widely when public protection is being pursued and personality disordered offenders are brought into hospital through the back door when they can no longer be detained in prison.

5. Detention in Hospital at End of Sentence

(a) Late transfers

As noted in Chapter 3, the practice of "ghosting" meant that the hospital DSPD units had to deal with a significant group of disgruntled and uncooperative patients transferred from prison close to their release dates. This had a negative impact on the work of the DSPD hospital units and on the treatment of patients who were cooperating (see Burns *et al.* 2011; Trebilcock and Weaver 2010b and Chapter 3). Such late transfers were criticised by the CA in the case of *R. (TF) v. SS for Justice* [2008] EWCA Civ 1457. This case appears to have prompted a change in policy at the Ministry of Justice. Nevertheless, late transfers continue to be a legal possibility.

In *TF*, the appellant had reached the reception area of the prison wearing his civilian clothes in anticipation of release when he was served with an order of transfer to hospital. The order was made on the grounds he was suffering from psychopathic disorder under the old MHA 1983 and that treatment was "likely to alleviate or prevent deterioration" in his condition. The CA held that as the decision to transfer TF to

hospital had been "taken right at the end of [his] sentence" it "involved depriving him of his liberty" (*TF*, para. 13). This, according to the Court, "heighten[ed] the scrutiny" the Secretary of State and the lower court reviewing his decision ought to have applied to the evidence in support of transfer. The Court "suggest[ed]" that where the decision to transfer was taken at such a late stage, it "[could not] simply be taken on the grounds that a convicted person will be a danger to the public if released (as understandable as that concern must be) but [could] only be taken on the grounds that his medical condition and its treatability (to use a shorthand) justify the decision" (*TF*, para. 18). The Court also stated that s.47 would "hopefully" only be used at the end of sentence "in very exceptional cases". In the event, the Court found that the reports supporting the decision to transfer were out of date and did not show that the doctors who had assessed TF had "applied their minds to treatability" (*TF*, para. 28).

In *R. (SP) v. Secretary of State for Justice*, the CA dealt with the issue of late transfers following the implementation of the MHA 2007. Close to his release date, the appellant, SP, had been transferred from the DSPD unit at HMP Frankland to the DSPD unit at Rampton hospital under s.47. The transfer direction relied on the reports of two psychiatrists and a letter from the clinical director of the Rampton unit offering SP a place. One of the psychiatrists had used an old form and had recommended the transfer on the basis that SP required placement in a high secure DSPD setting and that treatment there was "likely to alleviate or prevent a deterioration" in his condition. In her judgment, Lady Justice Arden noted that "SP was about to be released from prison when the transfer direction was made" and "the transfer direction therefore constituted a severe restriction on his personal liberty". Consequently, the transfer direction had to be "considered carefully" and could not be acted on unless the provisions of s.47 had been "scrupulously satisfied" (*SP*, para. 11). In the event, however, the judge considered that the Secretary of State was "entitled to give the reports a sensible meaning" and that "by necessary implication" the psychiatrist's report, even couched in the terms of the old MHA 1983, demonstrated that "appropriate treatment" was "available".

Leon McRae finds the decision in *SP* "particularly disappointing because it failed to develop the view taken […] in the earlier case of [*TF*] that late transfers […] should take place only in 'very exceptional cases'" (McRae 2015, p.67). He further states that in the view of the Court in *TF*, "a late transfer would be impeachable under domestic law and Article 5 of the Convention if taken solely on the grounds that 'a convicted

person will be a danger to the public if released (as understandable as that concern must be)'". It is argued, however, that McRae attributes too much importance to these statements of the Court. As noted above, the CA in *TF* was merely "hopeful" that late transfers would only take place in exceptional circumstances and sought to "suggest" decisions should not be taken on the grounds of public protection alone. In *SP*, Article 5 was recognised as the basis for the individual right to liberty of the person but the Court further recognised this was subject to the exception of detention on the grounds of "unsound mind".

The CA's comments in *TF* imply a concern that the new "appropriate medical treatment" test leaves room for transfer decisions motivated purely by public protection rather than by therapeutic considerations. This concern may also have prompted the Court in *DL-H*, discussed previously, to require Tribunals to consider what "discernible benefit" treatment may have on the patient. However, treatment "benefit" is not required by the MHA 1983 and the decision in *DL-H* implies a higher standard even than that set by the HL in *Hutchison Reid* under the earlier "treatability" test. As noted previously, the ECtHR held that the criteria for detention on the grounds of unsound mind under Article 5.1(e) do not require an individual's mental disorder to be amenable to treatment (*Hutchison Reid v. UK).* Taken together, these judgments may present no barrier to late transfers if the correct procedures in the MHA 1983 have been followed. However, *TF* and *SP* suggest that the Courts will take a dim view of such decisions and scrutinise them closely.

The Court's dicta in *TF* sent a message of judicial disapproval of the practice of late transfers and, according to interviewees, helped prompt a change in policy at the Ministry of Justice. The Ministry and NOMS now instruct that "prisoners should not be transferred to hospital at the end of sentence unless there is clear evidence that hospital admission is necessary on clinical grounds" (Ministry of Justice and NOMS 2010, para. 5.6 and 5.8). They also direct that "sentenced prisoners who may need transfer to hospital for treatment must be assessed for transfer at the earliest possible point in their sentence". Practical reasons for avoiding late transfers are acknowledged in the policy, indicating that some lessons have been learned from the experience of the DSPD units:

> The notional section 37 [hospital order] is not a suitable power for managing the risk posed by a prisoner after his release date. Hospitals may not readily accept a

> dangerous offender where restrictions do not apply. The prisoner will have been anticipating release and is likely to be angry if his liberty is further curtailed. He is unlikely to co-operate with medical treatment, and he may pose a risk of serious harm to other vulnerable people in the hospital (Ministry of Justice and NOMS 2010, para. 5.7).

Where hospital admission is necessary, the policy states that admission for assessment or treatment under the civil powers in s.2 and s.3 of the MHA 1983 is to be preferred. This is on the grounds that this procedure "demonstrates that the decision is clinically-led, and is not a misuse of the powers of the Mental Health Act to extend the sentence of the Court" (Ministry of Justice and NOMS 2010, para. 5.8).

The fact that the decision to detain in hospital under s.2 or s.3 is made by the hospital authorities and not by the Secretary of State may help to create the impression that the decision is "clinically-led". McRae suggests that the fact that "only medical practitioners preparing reports in respect of civil admissions are required to visit the proposed transferee within the 14-day period before submission" may also make a difference (McRae 2015, p.68). These subtleties may, however, be lost on an individual who finds himself detained in hospital shortly following his release from prison. Such a patient is likely to be just as, if not more, disgruntled than if he had been transferred towards the end of his prison sentence. He will also be in a similar legal position, as restrictions no longer apply to transferred prisoners once their release dates have passed. Thus, despite the change in policy, similar problems to those experienced by the DSPD units may be expected to continue in the future.

(b) Preventive detention as punishment

Detention in hospital on public protection grounds after sentence expiry may also be experienced as punitive by the patient. John Stanton-Ife (2012) recognises that detention in hospital necessarily involves some of the material deprivations that characterise imprisonment. These include limitations on freedom of movement, impaired comfort and amenity, isolation from friends, family and the community, reduced autonomy and loss of privacy. What seem to be missing are the "symbolic" aspects of punishment, which Stanton-Ife characterises as the communication of censure and blame and the intention to punish (Stanton-Ife 2012). While he acknowledges that detention under the MHA 1983 may be psychologically stigmatising for the individual, Stanton-Ife argues

that, unlike a criminal conviction, it is not intended to be so. Nevertheless, he concedes that "if a detainee is insensitive to the symbolic features of situations, the detainee may see little or no difference between civil detention and imprisonment" (Stanton-Ife 2012, p.153).

As Lucia Zedner comments, the "privileging of purpose" in distinguishing between penal and non-penal forms of state power "does not mitigate the pains imposed by coercive measures" (Zedner 2016, p.4). The transfer of an offender to hospital at the end of a determinate prison sentence, while not intended to punish, is a deprivation of liberty and may be experienced as an extension of the punitive sentence of the court. Furthermore, the types of treatments developed for the DSPD group in hospitals do not differ much from those deployed in prisons and include offence-focused interventions (see Burns *et al* 2011). Bill Glaser distinguishes sex offender treatment from involuntary committal for psychiatric treatment. The latter, he argues, "is not related to any offending behaviour displayed by the patient (except if such behaviour is symptomatic of a disorder), is not intended to be harmful per se (i.e. it must be ultimately beneficial for the patient), and does not (or at least should not) imply any moral disapproval of the patient's behaviour" (Glaser 2010, p.266). In sex offender treatment, on the other hand, traditional principles of mental health ethics such as putting the interests of the client first, beneficence and non-maleficence, respecting patient-therapist confidentiality, refraining from coercive treatment and offering a choice of therapies are brushed aside in the interests of protecting victims and the public (Glaser 2010). In light of this, Stanton-Ife's argument that detention in hospital is not punitive appears less convincing.

(c) Preventive detention as discrimination

The current legal framework is also in conflict with the United Nations Convention on the Rights of Persons with Disabilities (CRPD) of which the UK is a signatory. This document draws on a social model of disability, "articulated not in terms of limitations or impairments of disabled people, but as flowing from inadequate social responses to the particular needs of individuals in society" (Bartlett 2012, p. 753). Tensions may be seen between Article 5.1(e) ECHR, which allows the detention of "persons of unsound mind", and Article 14.1(b) of the CRPD, which states that "the existence of a disability shall in no case justify a deprivation of liberty". According to the UN High

Commissioner for Human Rights, the CRPD forbids "deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory" including in combination with "other elements such as dangerousness, or care and treatment" (UN High Commissioner 2009, para. 48).

The MHA 1983 and the *Winterwerp* criteria certainly fall foul of the standards of the CRPD and there are therefore grounds for doubting the British government's assurances that the MHA 1983 is CRPD compliant (Office for Disability Issues 2011; see also Bartlett 2012). The Mental Capacity Act 2005, often promoted as a more "progressive" instrument, may also be non-compliant as the concept of capacity is based on impairments arising from mental disability and may therefore be discriminatory (Bartlett 2012, p. 762). Coercive treatment for mental disorder may also fall foul of Article 17 CRPD, which asserts that "every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others". This sets a higher standard of respect for rights than Article 3 ECHR, which permits coercive treatment where this is justified by medical necessity (*Herczegfalvy v. Austria* [1992] ECHR 58).

In the view of the UN High Commissioner, while Article 14 CRPD precludes preventive detention on the grounds of disability, even in combination with other grounds, it does not prohibit preventive detention completely. This may be permitted where the legal grounds for detention are "de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis" (UN High Commissioner 2009, para. 48). Peter Bartlett argues that this would permit the possibility of "a general law of preventive detention" which could, for instance, "be introduced to detain people who are perceived as dangerous, irrespective of disability" (Bartlett 2012, p.773). This possibility is discussed in the next chapter.

6. Conclusion

It has been argued in this chapter that personality disordered offenders are often excluded from the benefit of therapeutic disposals due to doubts surrounding the amenability of their disorders to treatment and the uncertain relationship between their disorders, their previous offending and their future risk of recidivism. The analysis of the case law presented here shows that a selective interpretation is given to the issue of

"appropriate medical treatment" depending on which outcome is being pursued – the punishment of personality disordered offenders in prison or their preventive detention in hospital. The case law also reveals a worrying trend towards the prioritisation of risk management and punishment over the welfare of all mentally disordered offenders. This may be expected to lead to greater numbers of mentally disordered offenders being inappropriately placed in the prison system. It has also been argued that preventive detention at end of sentence continues to be a legal possibility and that this may be experienced as punitive by the individual.

It has been argued in this chapter that the law tends to regard personality disordered offenders as at least partially culpable for their crimes and, following the decision in *Vowles*, this is likely to lead to a punitive outcome. These defendants are also progressively being excluded from the scope of defences and pleas based on mental disorder due to the reliance of efforts to reform the law on cognitive tests of mental capacity. The current legal framework thus leaves unresolved the question of how far personality disordered offenders may be regarded to be responsible for their actions given that deficits in their capacity to control their impulses may prevent them from acting towards others "in the spirit of brotherhood" (Peay 2011a, p.232). On the other hand, the risk-averse treatment of these offenders by the mental health system, in which their reoffending may be regarded as "almost inevitable" (Trebilcock and Weaver 2010a, p.67), indicates a recognition that they lack voluntary control over their actions. In the next chapter, the differing conceptions of the personality disordered offender deployed by the law will be examined further. In addition, some suggestions as to how a normative framework that is more responsive to the needs of offenders with personality disorder may be constructed will be presented.

Chapter 7: The Role of Rehabilitation in the Management of Dangerous Personality Disordered Offenders

1. Introduction

Building on the analysis presented in both halves of this thesis, this chapter addresses two questions that are central to the argument. First, it seeks to unearth and examine the particular conceptions of the personality disordered offender that structure legal and policy responses to personality disordered offenders. Second, it questions whether the current framework provides an adequate response to the particularities of personality disordered offenders and whether a better way of resolving the dilemmas they present could be developed.

It will be suggested that the concept of responsibility for defective criminal character traced by Nicola Lacey (2001a; 2001b; 2011; 2016) may provide a means of reconciling the judgment that personality disordered offenders are responsible for their actions with the denial of autonomy implicit in the use of preventive detention. It will be argued that Nikolas Rose presents the most accurate characterisation of the DSPD offender as not "the juridical subject of the rule of law, nor that of the bio-psychological social subject of positivist criminology, but of the responsible subject of moral community guided – or misguided – by ethical self-steering mechanisms" (Rose 2000, p.321). This concept also provides an explanation for why personality disordered offenders must engage in rehabilitation in order to secure release or face further detention and punishment.

Furthermore, it will be argued that the offender's "duty" to engage in rehabilitation in order to prove his suitability for release may in fact subject him to further punishment and, ironically, jeopardise his chances of progress. Effecting preventive detention in non-punitive conditions and de-linking progress in rehabilitation from release decisions may provide a better means of safeguarding the rights and interests of personality disordered individuals thought to be "dangerous". However, any suggestions for reforming the current framework will have to take into account the symbolic nature of efforts to reassure a vulnerable public that the government is "doing something" to protect them from a group that provokes fear.

2. The Dangerous Personality Disordered Subject

(a) Positivism and Monsters

In Toby Seddon's view, despite the modern language of "risk" permeating the DSPD proposals, the initiative was "hybrid" in nature and combined "a novel focus on risk with a more archaic concern about dangerous subjects" (Seddon 2008, p. 309). Drawing on Jonathan Simon's (1998) analysis of American sexually violent predator laws, Seddon reasons that because DSPD "is essentially an unchanging characteristic" "the perceived causal link between their personality traits (which […] *are* the person) and their potential for serious violence [marked the DSPD group] out as 'monsters' requiring an exclusionary response" (Seddon 2008, p.309). Andrew Rutherford, on the other hand, links the DSPD proposals to "the warm embrace of risk and a vigorous renaissance of positivism towards offenders" that he argues were "underlying themes of New Labour's emerging criminal policy" (Rutherford 2006, p.51). Both accounts imply a deterministic view of the DSPD offender driven by internal or external forces beyond his control (Garland 1985, p.85).

The early DSPD proposals may have given the impression that a "revival" of positivism was underway as they implied a causal link between offending and severe personality disorder and assumed that treatment could therefore be expected to reduce risk of reoffending. It was argued in Chapters 3 and 4, however, that the programme soon retreated from the idea that personality and offending were causally linked and the entry criteria were applied flexibly (Burns *et al.* 2011). The OPDP has moved even further away from the idea of a causal link and has gone so far as to remove the need for a formal personality disorder diagnosis altogether. Furthermore, the focus of treatment has shifted away from the personality disorder itself towards behavioural interventions that are used to target risk factors for offending in mainstream prisoners (see Chapter 4).

Jonathan Simon sees civil commitment and registration laws as a punitive form of a "new penology" that seeks not to transform abnormal individuals but merely to incapacitate and exclude them (Feeley and Simon 1992). In the DSPD scheme, however, treatment and transformation were central to the bargain deployed to justify preventive detention. The types of intervention deployed on the DSPD programme and its successor, the OPDP, are further evidence that the DSPD initiative does not conceive of the offender as a "monster" subject to internal and external forces beyond his control.

Treatments on the DSPD programme seek to equip offenders with the skills they require to lead a law-abiding life, implying that the dangerous personality disordered offender is capable of learning to exercise control over his baser instincts. More holistic interventions also retain a place, implying that welfarism has not been wholly displaced by risk management. If the offender fails to participate or demonstrate change, however, he will face continued detention in prison or transfer to hospital on the grounds of the risk he poses to the public.

It was argued in Chapters 5 and 6 of this thesis that the law generally regards personality disordered offenders to be at least partially criminally responsible for their own actions. This implies that they are in control of their criminal behaviour and can exercise free will, in line with classical conceptions of the offender as a rational moral actor reflected in classical utilitarian and retributive theories of punishment. On the other hand, the use of preventive detention on the grounds of dangerousness, whether on an indeterminate sentence or under the MHA 1983, implies that those in the DSPD group cannot be expected to exercise their capacity for rational control to restrain themselves from offending. Here it will be argued that the concept of responsibility for defective criminal character provides a better explanation for these diverging conceptions of the offender than accounts based on positivism and classicism.

The figures of the redeemable and irredeemable offender seen in the Victorian notion of "reform" and in more modern forms of risk-based governance also provide an explanation for the hybrid inclusive and exclusionary control strategies deployed by the DSPD programme and the OPDP. Drawing on this analysis, it will be argued that the duty to engage in rehabilitation may be characterised as a moral duty and serves as an underlying justification for the punishment of personality disordered offenders who fail to reassure the public that they do not pose a threat. This preliminary step seeks to expose the assumptions underlying current approaches to personality disordered offenders so that they can be made subject to critique later in this chapter.

(b) Redeemable and irredeemable characters

Nicola Lacey's socio-historical account of the evolution of criminal responsibility shows that the Victorian concept of responsibility for defective criminal character pre-dates the modern subjective capacity-based responsibility that now dominates the criminal law and criminal law theory (Lacey 2001a). Furthermore, she argues that forms

of liability for defective criminal character continue to exist alongside modern capacity-based forms of criminal responsibility and are reflected in preventive measures taken against the dangerous (Lacey 2011). The concept of liability for criminal character is closely aligned with the penal strategies of reform and rehabilitation and provides a means of reconciling the seeming contradiction between the finding that the DSPD group are criminally responsible and the denial of responsibility implicit in the use of preventive detention.

According to Lacey, in the early 19th century and in opposition to the brutal and arbitrary system of early retributive punishment, "there emerged both a democratic concern for uniformity in the administration of criminal law and a powerful discourse of individual responsibility based on defective character" (Lacey 2001a, p.364). At this time, "it was not the capacity for understanding or opportunity for direct control of the criminal act itself but rather the capacity to work on one's character which was the important thing: defective, criminal character was understood as the failure to exercise general self-government or self-discipline" (Lacey 2001a, p.364). In character responsibility, "criminal behaviour was seen as proceeding from uncivilised, savage human nature; but through the announcement of a clear set of norms and threats, and through the intervention of the modern prison, proper habits of self-governance could be instilled into a deviant but potentially malleable population" (Lacey 2001a, p.364).

Rather than betraying "a belief in 'actual' responsibility in the sense of free will", character responsibility reflected "a governmental belief that the best way to get people to conform was to treat them *as if* they were fully responsible in the sense of having the capacity to work on their characters" (Lacey 2001a, p.364). Thus, individuals could be held responsible for their failure to exercise self-control and for reforming the defective criminal characters that allowed their baser instincts to prevail and led them to offend.

According to Lacey, notions of character and capacity "coincided within two strikingly different social philosophies" in early Victorian criminal justice:

> First, a moralised version of utilitarianism, in which the contemplation of consequences was expected to lead to more considered, rational (and, in this context, law-abiding) behaviour; second, Evangelicism, in which the contemplation of a future life was meant to have an improving effect upon self-discipline and hence character in the present one (Lacey 2001a, p.364).

The Victorian concept of "reform" was "a process of moral atonement […] to be brought about through moral exhortation and the grace of God" (Garland 1985, p.127). It was central to the 19th century "penitentiary" model that was intended to reform criminals through a combination of hard work, contemplation, and solitary reflection similar to monastic discipline (see Rotman 1990, Chapter 1; Hudson 2003, p. 27-8). Thus, reform and punishment were closely intertwined in Victorian times. In this sense, the offender was viewed as both morally responsible for his defective criminal character and potentially redeemable through the process of punishment and reform.

Some offenders were unmoved by the threat or experience of imprisonment, however, and appeared to be incorrigible by reformatory means. These "habitual criminals" presented a particular problem for a penal system founded on the principles of less eligibility and deterrence. Habitual offender legislation targeted persistent offenders, largely convicted of acquisitive crimes, subjecting them to increasing punishment by imposing progressively longer prison sentences for recidivism and heightened surveillance measures in the community through a system of release on licence (Godfrey *et al.* 2010). Those of defective character were thus divided into two groups: the corrigible, who were redeemable through reform, and the incorrigible or irredeemable who had to be confined to preserve the Victorian moral order. The measures were largely a failure and caught petty offenders rather than the truly dangerous.

(c) Penal welfarism and the survival of character

In the latter part of the 19th century, the "odd equilibrium of utilitarianism and Victorian moralism" began to break down, partly due to "a shift in world-view occasioned by the growing influence of the social and natural sciences, which gradually undermined confidence in individual responsibility for crime" (Lacey 2001a, p.365). In Garland's (1985) account, in the mid-to-late 19th century, economic decline was attended by high unemployment and a housing shortage led to increasing numbers living in poverty and unsanitary conditions. This gave rise to a social crisis that threatened the stability of the highly stratified Victorian society. In combination with scientific developments, this led to "a series of transformations that reconstituted the penal complex in a form designed to repair its disciplinary deficiencies and to re-establish legitimacy and public support" (Garland 1985 p.65).

For Garland, "the realm of penality became the chosen site for an extension of control, for a new mode of social administration which was underpinned and sanctioned by law but whose effects were not limited by it" (Garland 1981, p.39). The new system operated primarily through the "welfare sanction […] which takes as its object not a citizen but a client, activated not by guilt but by abnormality, establishing a relation which is not punitive but normalising" (Garland 1981, p.40). However, as Lucia Zedner comments, despite the dominance of welfarism in penal discourse, the courts continued their commitment to "classical legalism" and the fine was the most frequently imposed sanction (Zedner 2002, p.344). This casts doubt on the dominance of the "welfare sanction" in the penal welfare era and indicates that the criminal law continued to be "retributivist in its orientation" (Zedner 2002, p.345).

Lacey argues that while the "eclectic 'penal welfarist' settlement" described by Garland (1985) was being assembled and "the penal system was being reconstructed on more inclusionary lines" that saw "human character as shapeable by reformist interventions", "capacity-based and subjective principles of responsibility were continuing their steady progress in the courts" (Lacey 2011, p.172). A "strong conception of individual (mental) responsibility" reflected in the "doctrine of *mens rea*" began to develop (Lacey 1998, p.32). A capacity-based and subjective concept of *mens rea* could respond to the emergence of scientific evidence that not everyone was capable of fulfilling the ideal of the free and rational man, and concessions were made in the defences of insanity, infancy and diminished responsibility (see Loughnan 2012). This "protected criminal law's autonomy in the face of the multiplication of rehabilitative and other welfare-oriented discourses which impinged on the same terrain and which legitimised regulatory responses to human behaviour irrespective of individual responsibility or desert" (Lacey 1998, p.32). Thus, the criminal trial came to be dominated by classical conceptions of the offender as a rational actor.

As positivists largely failed to find new scientific interventions that went beyond existing measures aimed at reforming offenders (Garland 1985), the tenets of positivism were "gradually consigned to the academy rather than the prison or reformatory" (Lacey 2011, p.172). Thus, the post-conviction stages came to be dominated by the Victorian notion of "reform" rather than by the positivist concept of "rehabilitation".

Nevertheless, the division between the trial and post-conviction stages is not as clear-cut as it may seem. Forms of character liability persist in the criminal law and are difficult to reconcile with liberal criminal law theory's emphasis on capacity and moral culpability (Lacey 1987). For Lacey, "status offences or semi-status offences […] as well as regular recreations of 'dangerousness' categories, show that the impulse to organize responsibility-attribution along status lines is a pervasive one in the history of criminal law" (Lacey 2011, p.160).

The division between corrigible and incorrigible offenders also survived into penal modernism, indicating the longevity of the notion of criminal character. Measures for preventive detention of habitual offenders were re-introduced by the Prevention of Crime Act 1908. By 1932, owing to the objections of judges and liberal politicians, the regime had, however, become a "dead letter" (Home Office 1963, p.2). The use of preventive detention with persistent offenders was revived again in post-war Britain under the Criminal Justice Act 1948 and was also aimed at those who were thought to be beyond reform (Home Office 1963, p.9). The conditions of detention were to be "as little oppressive and as much superior to the conditions of ordinary imprisonment as might be compatible with safe custody and good order" (Home Office 1963, p.10). By July 1962, 1,171 men and 30 women were detained in prisons set aside for this purpose (Home Office 1963, v). The majority had been convicted of offences against property, with just 10% convicted of a violent or sexual offence, indicating that the measures were being used for those who were a mere nuisance rather than the truly dangerous (Home Office 1963, p.7-8). The damning conclusion of the *Report of the Advisory Council on the Treatment of Offenders* commissioned by the Home Office was that, although the public were protected for as long as preventive detention lasted, preventive detention was:

> Demoralising and embittering and does little, or nothing, to prepare most of [the detainees] for life in the outside world on their release; thus at the end of the sentence they are usually no more able to keep out of crime than they were before they began it (Home Office 1963, p.19).

The report concluded that the system of preventive detention should therefore be abolished and replaced by longer prison sentences available on the grounds of previous offending. The measures were formally abolished by the CJA 1967.

Lacey argues that a "resurgence" of character responsibility may be seen in the raft of preventive measures aimed at violent or sexual offenders. In her view, "risk of sexual harm or violent crime orders" impose forms of "(highly targeted) status liability" and sex offender registration statutes create "a quasi-criminal status" or "prima facie judgment of criminal propensity" which "sits unhappily with the idea of punishment as commensurate to crime" (Lacey 2011, p.168-9). As Lacey notes, "a criminal conviction resulting from the breach of any of these orders is a form of criminalization which applies specifically to a group identified in terms of its subjection to the relevant order" (Lacey 2011, p.168-9). Rather than targeting petty property offenders, these measures target serious sexual or violent offenders who threaten the security of the public.

As forms of character liability have gained increasing importance, the growing emphasis on reform and rehabilitation under the recent Coalition and Conservative governments may not come as a surprise. As penal policy prioritises the prevention of crime the purpose of the prison shifts towards preventive detention and reform. However, as the system continues to be influenced by retributivism, prison sentences are also conceived as a punishment. In character responsibility, these two elements are combined, as punishment is seen as a means of improving those with defective criminal characters who cannot be trusted not to reoffend.

(d) Character and risk-based governance

Andrew Rutherford (2006) saw the DSPD initiative as an example of Nikolas Rose's (2000) "risk thinking" in which the "excluded are not merely cast out but become subject to strategies of control". Measures are taken to "neutralise" those who for whom "social inclusion" is "impossible" (Rutherford 2006, p.82). Within these "exclusionary circuits" "a whole variety of paralegal forms of confinement" are devised for those who appear "intractably risky" and "may require waiving the rule of law" (Rutherford 2006, p.82, quoting Rose 2000). Rutherford's account neglects the other "circuit of exclusion" identified by Rose, however. By contrast to the new penology thesis, Rose argues that "whilst confinement without the aspiration of reformation is certainly on the increase in […] new control practices, it would be a mistake to think that the logics of control pay no attention to the transformation of the excluded individual" (Rose 2000, p.334). This is reflected in the circuit of exclusion that seeks "to reaffiliate the excluded […] and to reattach them to the circuits of civility" (Rose 2000, p.330).

Rose identifies three groups subject to circuits of exclusion: those who "have refused the bonds of civility and self-responsibility", those who are "unable to assume them for constitutional reasons" and those who "aspire to them but have not been given the skills, capacities and means" (Rose 2000, p.331). His model leaves open the possibility for the excluded to move into the circuits of inclusion and to become self-regulating, responsible moral citizens. These "circuits of security" are made up of "disciplinary institution[s]" that seek to "*mould* conduct by inscribing enduring corporeal and behavioural competences, and persisting practices of self-scrutiny and self-constraint into the soul" (Rose 2000, p.325). Through the process of normalisation, the individual internalises norms and comes to govern himself, meaning that the state can govern its citizens "at a distance" (Rose 2000, p.337).

On the other hand, "for those who cannot or will not be included, and who are too risky to be managed in open circuits – the repeat offender, the irredeemably anti-social, the irretrievably monstrous, the paedophile, the psychopath – control will take the form of more or less permanent sequestration" (Rose 2002, p.335). Such "harsh measures" against these individuals are justified as they have "refused the offer to become members of [the] moral community" (Rose 2002, p.335). In this system, "citizenship becomes conditional upon conduct" (Rose 2002, p.335). This implies that refusal to engage with the circuits of inclusion is met with a punitive and exclusionary response.

Rose's positioning of "the psychopath" in the category of the permanently excluded is likely to have led Rutherford to characterise the DSPD initiative as an exclusionary tactic. However, the DSPD programme was predicated on the notion that the dangerous personality disordered offender could be imbued with the skills needed to exercise the "responsible and prudent self-management" Rose argues is required for membership of a modern, civilised society (Rose 2010, p.96-7). These interventions focus on encouraging the offender to take responsibility for his own offending and criminogenic risk factors and to equip him with the skills he needs to make pro-social choices (see Ministry of Justice *et al.* 2011). Following Rose, therefore, the "pervasive image" of the DSPD offender is not "the juridical subject of the rule of law, nor that of the bio-psychological social subject of positivist criminology, but of the responsible subject of moral community guided – or misguided – by ethical self-steering mechanisms" (Rose 2000, p.321).

Erin Donohue and Dawn Moore's discussion of the "client" and "the offender" also offers an explanation for the alternating discourses of exclusion and inclusion that appear in discussions on the DSPD group. According to Donohue and Moore, "the client" is "a choice-making, engaged and participatory subject" and is used to recruit offenders and criminal justice workers into the contemporary penal project. "Clients" are "individuals whose illnesses and lack of skills, rather than inherently evil or opportunistic tendencies, lead them into crime and thus they are the individuals who will be led back out of criminality with the help of psy expertise and actors" (Donohue and Moore 2009, p.323). The language of the client is one of self-determination, choice, "consumer empowerment" as well as entitlement and rights to services (Donohue and Moore 2009, p. 327).

The authors contrast "the client" with the figure of "the offender", who can be seen on the "public face" of punishment and is the subject of "punitive rhetoric" (Donohue and Moore 2009, p.321). "Villainous, irredeemable and objectified, the offender does nothing once caught up in the [criminal justice system], she simply is the target of intervention" (Donohue and Moore 2009, p.321). Allusions by Jack Straw and Paul Boateng in parliament to dangerous psychopathic or sexually deviant offenders who had to be detained to protect the public may be seen to draw on the discourse of the "offender". On the other hand, in the balancing metaphor, the DSPD group was presented as having an entitlement or "right" to treatment that would help them back into the fold of responsible citizenship.

Rose characterises both inclusive and exclusionary practices as a means of controlling the population but his account lacks an explanation for why inclusive strategies are used where exclusionary ones would achieve the same effect. Kelly Hannah-Moffat provides one in her discussion of the "transformative risk subject" she argues is the target of current rehabilitative interventions with offenders. According to Hannah-Moffat, the "fixed or static risk subject" (Hannah-Moffat 2005, p.34) of "actuarial justice" (Feeley and Simon 1992) leaves no room for change and threatens the legitimacy of interventions with offenders (Hannah-Moffat 2005, p.40). "Transformative risk subject[s]", on the other hand, can be taught "how to manage their criminogenic needs and reduce their risk of recidivism by acquiring the requisite skills, abilities, and attitudes needed to lead a pro-social life" and to become "prudent and rational risk managing subject[s]" (Hannah-Moffat 2005, p.42; p.40).

The transformative risk subject fits well with "political and humanistic commitment[s] […] to 'do something' that will facilitate reintegration and rehabilitation" (Hannah-Moffat 2005, p.29; p.34). This can be seen in the concern of DSPD policymakers not to simply "write off" dangerous offenders but to offer them the means for re-integration. The goal was not just to reduce risk to the public but also to work towards re-integrating those with the potential to become functioning citizens. Interviewees described the DSPD group as "damaged" and the role of government was to "do what we should to try to help them to fit into society a bit more" (Civil Servant). The ultimate aim of the system was to reintegrate the individual back into society, "to their benefit as well as society's", and to enable them "to live more fulfilling lives for themselves" (Civil Servant).

Rose's excluded individuals and Donohue and Moore's "client" and "offender" seem to echo the redeemable and irredeemable subjects seen in the Victorian period of "reform" and the penal welfare era. Robinson argues, however, that while current strategies "reprise [the] themes of personal responsibility, choice and recognition of the moral implications of those choices" they do not "re-invent the sinner of pre-modern reformative efforts" (Robinson 2008, p.438). Rather than a process of "moral atonement" coming about through the "grace of God" (Garland 1985, p.127) as in Victorian times, the DSPD programme and its successor seek to redeem the personality disordered offender through psychological interventions. For Rose, through the techniques of "remoraliz[ation]" and "responsibilization", re-inclusion strategies seek "to reconstruct self-reliance in those who are excluded" (Rose 2000, p.334). A "language of empowerment" is employed and exclusion is reformulated as "lack of self-esteem, self-worth and the skills of self-management necessary to steer oneself as an active individual in the empire of choice" (Rose 2000, p.334).

Rather than blaming others for their problems, individuals are encouraged to identify their own "collusion" in their difficulties and to overcome them (Rose 2000, p.334). Thus, "autonomy" is "represented in terms of personal power and the capacity to accept responsibility". Empowered subjects are expected to "work on themselves, not in the name of conformity, but to make them free" (Rose 2000, p.334). The use of psychotherapeutic approaches with the DSPD group implies that the aim of the system is to prompt them to engage in the process of self-discovery and self-actualisation that Giddens (1991) identifies as "the new individualism". In order to be able to engage with

the world again, however, offenders will not only have to come to understand themselves better but also respect the "vulnerable autonomy" of others (Ramsay 2012a).

The distinction between redeemable and irredeemable offenders may therefore provide a further means of understanding the "hybrid" nature of the DSPD initiative. Rehabilitation and eventual release may be conceived as a response to the redeemable subject whilst indefinite preventive detention is a response to the irredeemable – those who are unable or who refuse to engage with treatment and cannot therefore be re-integrated into the circuits of inclusion (Rose 2000).

3. Criminal Responsibility and Punishing the Personality Disordered Offender

(a) Character and capacity

Accounts of the criminal responsibility of the DSPD group have also drawn on the notion of positivism. According to Rutherford, the promotion by forensic psychologists of the notion that personality disordered offenders were treatable was a "revival of criminological positivism and its message of optimism" (Rutherford 2006, p.72). Rutherford argues that, in the DSPD scheme, "ultimately an agenda of public protection places issues of risk to the fore of those of individual rights and the accent becomes pre-emptive rather than reactive" (Rutherford 2006, p.83). Positivism, according to Rutherford, is focused on the prevention of crime and was "untrammelled by the so-often tortuous process of harmonising the legal definition of responsibility with the mental state of a particular offender, disregard[ed] the traditional concepts of moral guilt, expiation or retribution [and] reject[ed] the insistence upon proportionality between crime and punishment" (Radzinowicz 1999, p.16, quoted in Rutherford 2006, p.84).

In the "third service" model, there would have been no need for a conviction before an individual meeting the DSPD criteria could be made subject to preventive detention in a specialist unit. This seems to accord with positivism's disregard for concepts such as "'free will, 'responsibility', 'guilt' and 'punishment'" which were seen by its proponents as "not just fictions out of favour with science, but metaphysical concepts which posed a danger to society's security" (Garland 1985, p.85). However, the "third service" idea never came to pass and the majority of those in the DSPD units were

given prison sentences (Trebilcock and Weaver 2010a; 2012a). Personality disordered offenders are also generally regarded by the Courts and the Law Commission to be at least partially responsible for their offending and therefore deserving of punitive prison sentences rather than therapeutic hospital disposals (see Chapter 6). Yet, those in the DSPD group and on the OPDP are also judged to be too risky to release and are preventively detained in prison on indeterminate sentences or in hospital under the provisions of the MHA 1983.

Ashworth and Zedner (2014) express the problem posed by the preventive detention of the "dangerous" as "how to square the tacit denial of responsibility entailed in saying that an individual is incapable of restraining their dangerous violent or sexual impulses with the judgement that the same individual can justly be held responsible for past criminal conduct" (Ashworth and Zedner 2014, p.149). Anthony Bottoms has sought to explain this tension by highlighting the dominance of "classical" and "positivist" conceptions of the offender at different stages in the criminal justice system:

> Western legal systems typically treat offenders as freewill rational beings in the early stages of police processing and the determination of guilt by the court (classicism). In later stages, notably in prison and probation treatments, the emphasis typically shifts to pathology and psychic disturbance (positivism) (Bottoms 1977, p.92, n.8).

Harry Annison argues that the IPP sentence "goes with the grain" identified by Bottoms (1977) because it does not affect the determination of guilt by the court but merely provides it with "an additional sentencing option that is preventive in its outlook and positivist in its underlying assumptions" (Annison 2015, p.62). However, like the view of the DSPD offender as a "monster" (Seddon 2008, p.309), the conceptualisation of criminality as "pathology" in Bottom's account leaves little to individual agency. It also fails to account for the finding that the personality disordered offender is both responsible for his offending and has a duty to reform himself in order to progress towards release.

The concept of responsibility for defective criminal character may provide a better explanation for seemingly alternating conceptions of the "dangerous" offender at different stages of the criminal justice system. As argued in Chapter 6, reform proposals for defences based on mental disorder tend to focus on individuals' cognitive rather than

volitional capacities and do not take full account of the deficits of personality disordered offenders. The concept of partial responsibility is also used to justify punishing personality disordered offenders for any particle of responsibility they bear for their offending (Ashworth and Macakay 2015). Similarly, the concept of responsibility for defective character underlying preventive sentencing does not require answers to the difficult question of whether personality disordered individuals can justly be said to be in control of their actions. This is because it treats the offender "as if" he is "fully responsible" on the grounds that he has the capacity to "work on" his character (Lacey 2001a, p.364).

(b) Breaching the duty to engage in rehabilitation

David Garland (1996) and Pat O'Malley (1999) characterise recent trends in criminal justice as "volatile and contradictory" and tend to place rehabilitation and preventive detention in opposition to each other. O'Malley describes trends in criminal justice policy as "inconsistent and sometimes contradictory couples" that include "incapacitation and warehousing versus correctional reform, punishment and stigmatization versus reintegration" (O'Malley 1999, p.176). He attributes this "incoherence" to the contradictory elements of "New Right politics" which "extends the repertory of penality simultaneously in 'nostalgic' (neo-conservative) and 'innovative' (neo-liberal) directions" (1999, p.175). Toby Seddon also saw "inconsistencies" between the "apparent disregard for civil liberties" in the DSPD proposals and the "therapeutic innovations" that developed within the DSPD units (Seddon 2008, p.310).

Garland, on the other hand, attempts to explain the "volatile", "contradictory" and "ambivalent" nature of penal policy in terms of the limits on the power of the sovereign state to control crime (Garland 1996). In his view, governments vacillate between rational "adaptive strategies", in which they accept such limitations, and punitive "strategies of denial", through which they hysterically attempt to re-assert their power (Garland 1996, p.445). According to Garland, "adaptive strategies" can be seen in relation to rehabilitation, as prison authorities no longer make ambitious claims about their ability to rehabilitate individuals but focus more narrowly on incapacitation while shifting responsibility onto prisoners to make use of those opportunities for reform that are offered to them (Garland 1996, p.458). On the other hand, punitive "strategies of denial", including measures of "custodial incapacitation" and "powers to pass very long

sentences on certain offenders", "express popular feelings of rage and frustration in the wake of particularly disturbing crimes" and also claim to pursue the instrumental purpose of controlling crime (Garland 1996, p.460).

The characterisation of rehabilitation as "progressive" and lengthy or indeterminate prison sentences as "punitive", "populist" and "emotive" overstates the differences between these approaches, however. Garland's focus on the claim that rehabilitative efforts are "instrumental", in the sense that they are intended to reduce risk of reoffending, may have led him to disregard the more punitive elements of such interventions. In Garland's earlier work, he argues that notions of "reform" rooted in Victorian evangelical utilitarianism and the positivist notion of rehabilitation coexisted into the early 20th century in a "penal welfare settlement" (Garland 1985). Despite the confidence of positivists that criminal behaviour was caused by scientifically discoverable internal or external factors, new scientific interventions going beyond traditional reformative methods were lacking. Therefore, the practice of rehabilitation came to rely on the interventions deployed in the name of reform. Interventionist penal measures that "clearly flouted the traditions of liberalism" were made palatable for a Liberal government through appeals to "the 'moral duty' of a charitable state to extend its 'care' and 'protection' to those in need of 'rescue'" (Garland 1985, p.209). This "'evangelised' version of criminology" dissolved political issues into "questions of care and benevolence" (Garland 1985, p.209). Coercion was never far from the surface, however. "The rewards, provisions and benefits" of the social sphere were "conditional upon certain norms of conduct" and these "terms" were "negatively reinforce[d]" by the penal system, which "threaten[ed] to deal coercively with those who refuse them" (Garland 1985, p.233).

Punitive and coercive language may be seen in relation to the recent revival of rehabilitation, which seems to hark back to the Victorian notion of reform, which took place through punishment and the intervention of the modern prison. In the 2010 Green Paper *Breaking the Cycle*, the Coalition government asserted that criminals would be met with "more effective, tough punishments" and that prisons would become "places to learn the link between hard work and reward" (Ministry of Justice 2010a, p. 9). The plans also asserted that offenders had a responsibility to reform themselves and this was backed up with a threat of punishment. Thus, they would be required "to take the action needed to change their criminal lifestyle" and "swiftly caught and punished if they [did]

not accept the opportunities offered to them and instead return to a life of crime" (Ministry of Justice 2010a, p. 25).

A recent speech by Minister for Justice Michael Gove indicates that the Evangelical notion of "reform" and Victorian moralism continue to be intertwined with rehabilitation in the Conservative government's policies. The Minister spoke of the need for "a new and unremitting emphasis in our prisons on reform, rehabilitation and redemption" (Gove 2015). He stressed that offenders "have to be punished because no society can protect the weak and uphold virtue unless there is a clear bright line between civilised behaviour and criminality" (Gove 2015). He also called for prisons to be places in which "offenders whose irresponsibility has caused pain and grief can learn the importance of taking responsibility for their lives, becoming moral actors and better citizens" (Gove 2015).

For Ashworth and Zedner, preventive detention is a denial of autonomy as it removes "the moral opportunity to exercise choice to reflect, repent, and to resist temptations to engage in wrongdoing in the wider world" (Ashworth and Zedner 2014, p.150). "Whereas conviction for a crime past rests upon the claim that the individual acted culpably at a particular point in time, the decision to detain preventively […] relies upon the assertion that the character traits of the detainee are enduring and predictable" (Ashworth and Zedner 2014, p.150). They argue that "the judgement that an individual poses a significant risk of serious harm" implies that "he does not have the capacity to choose to do right" or, "at the very least", that "he will not in fact exercise that capacity to restrain himself" (Ashworth and Zedner 2014, p.150). Ashworth and Zedner's two categories echo Nikolas Rose's distinction between excluded individuals who lack the ability to conform and those who refuse the bonds of civility. The underlying justification for the continued detention of those of incorrigible bad character is their refusal of the moral order and their continuing dangerousness. Punishment is more difficult to justify as response to the irredeemable offender who cannot conform. Instead, preventive detention may be seen as a response to his dangerousness.

Preventive detention may be seen to be a punitive response to individuals who have breached the moral order by offending. The exclusion of volitional capacities from subjective capacity-based responsibility allows personality disordered offenders to be punished for transgressions they may not have been able to restrain themselves from.

The concept of responsibility for criminal character also sees them as responsible for reforming their defective criminal characters. Furthermore, the DSPD initiative has important symbolic value as a response to public fears of dangerous mentally disordered offenders that go beyond its "instrumental" promises to protect the public. Drawing on Ramsay's theory of the ideology of vulnerable autonomy, the failure to reassure others of one's safety is constructed as a wrong to be punished. Those who refuse to engage are also to be punished for their refusal to become moral citizens of the modern world and pursue their own self-actualisation while maintaining a regard for the protective cocoon of others (Rose 2000; Giddens 1991). The promise of rehabilitation is that it allows for a distinction to be drawn between those who are redeemable and irredeemable.

This framework breaks down in practice, however, as the DSPD programme and the OPDP have not yet found a means of differentiating between the redeemable offender, those who are unable to conform and those who refuse to do so. Neither has it shown convincingly that it can mould redeemable personality disordered offenders into responsible citizens. This difficulty stems in part from the characteristics of personality disordered offenders, who do not straightforwardly divide into those who cannot conform and those who choose not to do so. According to Hanna Pickard, insofar "as violent behaviour (in those with or without PD) is responsive to incentives, it appears to be subject to choice and a degree of control" (Pickard 2015, p.20). The reduction in violence seen in the tightly controlled DSPD units implies that personality disordered offenders do have the capacity to control, or at least re-direct, their violent impulses when they are under close observation. Nevertheless, such individuals may experience great difficulty in exercising control over their behaviour, particularly given that violence is often a habitual or learned response to emotional distress (Pickard 2015, p.20).

The failure of the DSPD programme to separate out the redeemable and irredeemable has resulted in the expectations for the programme being scaled down. The programme now focuses more closely on "the generation of 'knowledge that allows selection of thresholds that define acceptable risks'" that inform the practices of inclusion and exclusion (Rose 2000, p.333). Nevertheless, the possibility of redemption through psychological intervention is left open. It will be argued in the next section that the assumptions underlying the current framework present particular threats to personality

disordered offenders. Furthermore, it undermines the goals of social reintegration and public protection and the possibility for the promise of rehabilitation to act as a brake on disproportionate punishment.

4. The Risks of the Current Framework

(a) The risk of harsh treatment

As argued previously, rehabilitation has been historically intertwined with punishment as a response to both redeemable and irredeemable offenders. Robinson (2008) argues that current efforts at the rehabilitation of offenders may be characterised as "punitive" or "expressive" as they involve "the communication of censure" (Robinson 2008, p.438). Interventions are "offence focused" and emphasise that the offender has "done wrong" (Robinson 2008, p.438). They also encourage offenders to "think ethically" and "develop a capacity for 'victim empathy' which, it is hoped, will serve to dissuade them from future offending" (Robinson 2008, p.438). The clinical concept of "responsibility without blame" described by Nicola Lacey and Hanna Pickard may offer a means of avoiding the punitive effects of rehabilitative interventions with offenders.

Lacey and Pickard define "affective blame" as "the range of hostile, negative attitudes and emotions that are typical human responses to blameworthiness" (Lacey and Pickard 2013, p.3). They argue that the retributive "justice model" "forges a strong association between the justification of punishment, the attribution of responsible agency in relation to the offence, and the appropriateness of [affective] blame" as "deserved" by the offender (Lacey and Pickard 2013, p.2). In the clinical model of "responsibility without blame", patients are also judged to be "responsible and indeed accountable for wrongful or harmful conduct to the extent that they possess the relevant cognitive and volitional capacities in relation to it" (Lacey and Pickard 2013, p.2). In contrast to the justice model, however, responsibility without blame "resists any corresponding tendency towards affective blame" (Lacey and Pickard 2013, p.2). Lacey and Pickard argue that, if the model of responsibility without blame were brought into the legal realm, "rehabilitation need not entail the effacement of moral responsibility, and justice need not entail the hard treatment and stigma that is typical of affective blame, even when negative consequences are justified and imposed" (Lacey and Pickard 2013, p.3). In this

sense, the concept of "responsibility without blame" used in clinical psychology could provide a means of reconciling retributive punishment with the rehabilitative ideal (Lacey and Pickard 2013, p.3).

Nevertheless, the use of psychotherapeutic approaches with personality disordered offenders involving the exploration of difficult traumatic experiences in a coercive prison or secure hospital setting raises the prospect that therapy itself will be experienced as harsh treatment. This may be the case even where therapists aim to avoid "affective blame" as suggested by Lacey and Pickard (2013). Dawn Moore and Kelly Hannah-Moffat (2005) contend that the use of offending behaviour programmes based on cognitive behavioural therapy (CBT) in the prison context is essentially punitive. They see a continuation of the oppressive practices of the penal welfare era operating under the "liberal veil of the free subject who makes his or her own choices" (Moore and Hannah-Moffat 2005, p.86). Therapeutic interventions in the prison setting may be experienced as punitive because the prisoner is forced to face traumatic past experiences, come face-to-face with his or her problems or inadequacies, has no right to choose a therapist and is separated from family and friends (Moore and Hannah-Moffat 2005). In their view, the use of interventions that emphasise freedom of choice serves to mask the underlying punitiveness of rehabilitative interventions and seems cruelly ironic in a context in which prisoners have little control over their own circumstances (Moore and Hannah-Moffat 2005).

Furthermore, rehabilitative interventions can pose risks to the wellbeing of prisoners. Elaine Genders and Elaine Player argue that current criminal justice policy "supports rehabilitative opportunities that address the risks offenders pose to the public, yet remains inattentive to the risk of harm that rehabilitative programmes can pose to offenders" (Genders and Player 2014, p.434). The authors note that the target populations for the "Rehabilitation Revolution" in the UK are typically composed of individuals "serving long sentences for serious offences, who have personal histories shaped by physical and sexual abuse and other risk factors associated with social disadvantage and exclusion" (Genders and Player 2014, p.451). Therapeutic interventions with such individuals "break down barriers between their public and private self" to expose "levels of trauma that reflect the adversity of the social worlds they have inhabited, as well as the complexity of their psychological needs" (Genders and Player 2014, p.451). Furthermore, the discussion of offence histories in group

therapy can expose prisoners to victimisation from other inmates, particularly where sexual offenders are mixed in with those who have been victims of sexual abuse (Genders and Player 2014). According to Genders and Player, the vulnerability this produces "demands professional skill and expertise and lies at the heart of the duty of care that is owed to these prisoners" (Genders and Player 2014, p.451). The authors note that the plans for the OPDP seem to indicate that such skills and expertise are not already in place, casting doubt on the programme's ability to care adequately for these individuals and protect them from harm.

The prison environment may also be re-traumatising (Jones 2015). The harmful social and psychological effects of imprisonment have been well documented and include separation from family, friends and social networks, loss of employment and housing, threats to physical safety and risks to physical and mental health (Liebling and Maruna 2005, Chapter 1). For those suffering from mental illness, prison can also "exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide" (Bradley 2009, p.7). Those diagnosed with BPD are particularly at risk, with between 60 and 70% having attempted suicide during their lifetime (Oldham, 2006). There is also evidence of a heightened risk of self-harm, suicide and suicide attempts amongst those diagnosed with ASPD (Verona *et al.* 2001). Frontline staff in the DSPD units were reportedly shocked at the levels of self-harm amongst patients and prisoners and the constant demands placed on them (Trebilcock and Weaver 2010b). There are indications, therefore, that personality disordered patients and prisoners may be at a heightened risk of self-harm and suicide which may be exacerbated by the experience of imprisonment.

Psychological assessment and intervention may also serve to exacerbate the pains of imprisonment and the hard treatment imposed by imprisonment. Ben Crewe's (2011) work on the modern "pains of imprisonment" describes the "pains of psychological assessment" and "the pains of self-government" that have emerged as "psychological power" has replaced more overt forms of physical power in the prison (Crewe 2011). The "pains of self-government" stem from the use of responsibilization strategies with prisoners. Here, "the prisoner is given greater autonomy – in a limited and localized way – but is enlisted in the process of self-government and held responsible for an increasing range of decisions" (Crewe 2011, p.519). This limited freedom is described by one prisoner as being given "enough rope to hang yourself" (Crewe 2011, p.519;

p.509). According to Crewe, "prisoners are on edge less because they are fearful of staff than because they themselves might 'cock up' their situation" (Crewe 2011, p. 519).

Prisoners experience psychological assessment as dehumanising as it deprives them of control over their own identities by casting aside any interpretations that do not fit into psychological discourse (Crewe 2011). The "pains of psychological assessment" also give prisoners a sense that psychological interpretations of their behaviour are "inescapably negative" (Crewe 2011, p.517). The feeling that "any comment can be used against [them]" in psychological risk assessments is experienced as "both dizzying and suffocating" by prisoners (Crewe 2011, p.517). In contrast to physical power, which takes a more brutal and overt form, "psychological power suspends itself perpetually, never quite revealing when it might take effect" (Crewe 2011, p.518). This leaves prisoners with a sense of "ontological insecurity" (Crewe 2011, p.513, citing Giddens 1991).

The use of psychological assessment and intervention in prisons may be said to compromise the "ontological security" of prisoners in order to protect the subjective security of the public. The sense of insecurity experienced by prisoners may further jeopardise efforts to encourage them to pursue self-actualisation through psychotherapy. The experience of prison may be more punitive for those who are subject to greater psychological monitoring and input, such as those serving indeterminate sentences and those who have been selected for the DSPD programme and the OPDP. The linking of participation in rehabilitative interventions and risk assessments to release decisions also implies that prisoners are to some extent coerced into participation, and this may further undermine the effectiveness of psychological interventions that require willing participation and motivation to change.

(b) The risk of excessive detention

It may be questioned whether punishment and preventive detention coupled with the promise of rehabilitation is the correct response to personality disordered offenders given their particular characteristics. Some of the traits of the psychopath include lack of remorse and a failure to learn from experience - both qualities that may make them less likely to be deterred by the prospect or experience of punishment. Individuals with psychopathic or antisocial traits may also be expected to encounter difficulty in responding to treatment programmes that require them to take responsibility for their

offending or to show remorse or empathy for their victims (Peay 2011a, p.233). Treatment programmes designed for mainstream offenders, even when adapted to personality traits such as proneness to boredom, may therefore struggle to elicit the expected responses from personality disordered offenders, who may then find it difficult to make progress or to demonstrate a reduction in risk.

Proving a reduction in risk through treatment is likely to be a slow process for offenders in the former DSPD units and on the OPDP. It is difficult for prisoners to demonstrate reductions in risk when they are in a high security setting but concerns regarding their dangerousness and high risk status seem to preclude more realistic tests of risk reduction in lower security settings (Trebilcock and Weaver 2012a; 2012b). Furthermore, as manipulativeness is a key feature of psychopathy and ASPD, seeming cooperation with treatment can be construed as an attempt to subvert the process. Dany Lacombe (2007) in her ethnography of a sex offender treatment programme in prison amply illustrates this problem. Worryingly, participants found themselves in a paradoxical situation. In order to show progress, they had to internalise the teachings of the programme and confess to having deviant sexual fantasies, leading some to invent such fantasies. If they complied too well with the programme's teachings, however, they opened themselves up to accusations of manipulation and psychopathy.

This Catch-22 is also reflected in the IMPALOX study. It was found that participants "were discouraged by the interpretation of their behaviour by psychologists: cooperation, for example, could be interpreted as manipulation, and there was disillusion and confusion about the attribution of labels (such as psychopath), and the ability of individuals to demonstrate change (diminished risk)" (Tyrer *et al.* 2010, p.98). The interpretation of "treatment interfering behaviours" as manifestations of personality disorder (Saradjian, Murphy and McVey 2010) is likely to contribute to the maintenance of this Catch-22 for those selected for the OPDP. The application of a personality disorder label to individuals not clinically diagnosed with personality disorder is particularly problematic as the personality disorder label is very difficult to remove once applied.

In the literature on both the Chromis and HMP Whitemoor programmes, "treatment interfering behaviours" are explicitly understood as manifestations of the individual's personality disorder. These include refusal to engage in treatment and excessive

recourse to complaints procedures, lawyers and litigation (Murphy and McVey 2010, p.136). This leaves little room for consideration of the effects of the coercive prison environment and the consequences of participation and non-participation in treatment for prisoners. As personality disordered offenders generally retain mental capacity (Peay 2011a) they may be very well aware of how the system works and the constraints operating on their choices. In some circumstances, their responses may therefore be better understood as a rational or normal response to the problematic situation in which they find themselves than as a symptom of disorder. As Leon McRae comments, the strategy of seeking treatment in a medium secure unit in order to expedite release "was generally taken as evidence of the very behaviour justifying the diagnosis of [severe personality disorder], rather than a form of amoral currency spent to avoid the threat of preventive detention. Yet, presumably most, if not all, of us would take remedial action to avoid such a threat" (McRae 2015, p.331).

Personality disordered offenders also pose particular problems when it comes to treatment engagement. While individuals diagnosed with BPD tend to be treatment-seeking and demanding of services, those diagnosed with ASPD are less likely to perceive themselves to be in need of treatment and tend actively to resist it (NCCMH *et al.* 2009; 2010). As noted in previous chapters, much of the work of the DSPD units involved motivating prisoners and patients to engage with treatment. As the types of treatment deployed generally require the active participation of the patient and motivation to change, coercive approaches are unlikely to be successful. Implicit coercion may be present in the prison environment in which prisoners are expected to comply with rehabilitative programmes or face sanctions or be denied the possibility of parole and this may jeopardize the effectiveness of treatment with this group.

Those patients and prisoners who consented to treatment on the DSPD programme reported lower levels of perceived coercion than those who did not consent (Zlodre *et al.* 2015; Burns *et al.* 2011). Furthermore, those who did not consent to treatment had lower levels of competence to consent to treatment (Zlodre *et al.* 2015). Decreasing perceived coercion and enhancing competence to consent to treatment may therefore be expected to enhance voluntarism and lead to improved clinical outcomes for personality disordered patients (Zlodre *et al.* 2015, p.2). This echoes Tyrer and colleagues' suggestion that "concentrating the resources on those who are clearly motivated and determined to overcome their propensity to re-offend may be one way forward" for the

DSPD programme (Tyrer *et al.* 2010, p.98). This route has not been adopted by the OPDP, however, which continues to prioritise those who are "high harm" rather than those who are motivated for treatment. This implies that the focus of the OPDP on those who present the highest risk to the public may further jeopardise the success of efforts at rehabilitation. This again casts doubt on the potential for rehabilitation to act as a safeguard against disproportionate preventive detention, particularly where participation is tied to release.

5. The Third Service Revisited

Andrew Ashworth and Lucia Zedner (2014) recognise that legitimate limits can be placed on certain individuals' autonomy to protect that of others, such as potential victims. However, in line with Peter Ramsay, they argue that this seems to prioritise the rights of unknown potential victims over concrete offenders (Ramsay 2012b, p. 206 Ashworth and Zedner 2014, p.150). The cases of *Mastromatteo* and *Maiorano* appear to do just that and indicate that the security of the public takes precedence over the right of the offender to rehabilitation and social reintegration. In this section some suggestions will be put forward as to how a new legal framework could respond to the problem of dangerous offenders while taking into account the risks posed by reliance on rehabilitation as a curb on preventive detention. The suggestions draw on the proposals for a "third service" and the limits traced around the use of preventive action by Ashworth and Zedner (2014). Any proposals to reform the current system will, however, also have to take account of the symbolic nature of efforts to reassure the public that something is being "done" to protect them from dangerous offenders.

(a) Preventive detention in prison

It has been argued in this thesis that reliance on rehabilitative interventions as a means of rendering preventive detention proportionate to the need to protect the public is problematic. Preventive detention in prison presents particular problems. Ashworth and Zedner (2014) argue that preventive detention is a violation of the presumption of innocence, as it punishes the offender for what he "might" do rather than what he has done, and it also violates the principle of retributive punishment. Furthermore, the statement of penal reformer Alexander Paterson that "men are sent to prison as

punishment, not for punishment" (Ruck 1951, p.13) implies that deprivation of liberty *is* punishment and therefore the longer the offender is preventively detained, the more he is being punished. This is exacerbated by the fact that the preventive and punitive portions of indeterminate and extended determinate sentences are currently served in the prison environment.

Ashworth and Zedner (2014) are critical of the use of risk-based indeterminate sentences where these violate the principle of proportionate punishment. The authors propose that everyone should have a right to be presumed harmless and that preventive action should only be taken by the state to protect individuals from "a significant risk of serious harm" where someone has lost that right through violent offending. Furthermore, they suggest that the burden of proving an individual presents a risk of violence should be placed on the state; judgments of dangerousness should be based on an individual assessment; decision-makers should be mindful of the contestability of such judgments; and the decision to detain should be open to appeal (Ashworth and Zedner 2014, p.169-170). Given the limitations of risk assessment, however, the "significant risk of serious harm" threshold recommended by Ashworth and Zedner may be more likely to relate to levels of public tolerance for risk or attitudes towards particular groups than to any objectively measurable "need" to protect the public.

Ashworth and Zedner further propose that those detained should also have access to "adequately resourced risk-reductive rehabilitative treatment and training courses" and preventive detention should take place in "non-punitive conditions with restraints no greater than those required by the imperatives of security" (Ashworth and Zedner 2014, p.169). Where possible, this should be in a facility separate from the prison system. These proposals are strikingly similar to the "third service" idea in the DSPD proposals (see Chapter 2). This is not surprising as both sets of proposals draw on the use of preventive detention in other European countries reflected in the case law of the ECtHR.

Ashworth and Zedner also propose setting a high threshold of harm and recommended an individualised approach to assessment, regular reviews of detention and the provision of risk-reducing treatment interventions in non-punitive conditions. These suggestions continue to rely on the provision of risk-reductive treatments to offenders in order to allow them to progress towards release. As argued previously, the use of such treatments under conditions of coercion may also expose the personality disordered

offender to excessive punishment and jeopardise the effectiveness of any treatment intervention in reducing risks to the public. The continuing lack of evidence for effective treatments for offenders with personality disorder, and particularly ASPD, casts particular doubt on the prospects for rehabilitative intervention to allow this group to progress towards release. The requirement of parsimony in Ashworth and Zedner's recommendations is, however, preferable to the ECtHR's broader brush approach of approving detention insofar as it is "proportionate" to the risks presented to the public. Nevertheless, the slippage between actual and symbolic protection mentioned previously may call into question what "necessary" or "proportionate" means in this context.

Demands for punishment are influenced by public appetites, which may be excessive or overindulgent (Loader 2009) and the public appetite for security and protection may be described as "insatiable" (Loader 1997, p.151). Lucia Zedner observes that "absolute security (objective or subjective) is a chimera, perpetually beyond reach" (Zedner 2003, p.157). New threats uncover "unknown vulnerabilities" and the pursuit of security consequently "requires continuing vigilance" (Zedner 2003, p.157). A parsimonious approach towards the problem of dangerous offenders risks provoking public fears if measures are perceived to be insufficient to ensure the safety of the public from those who threaten.

(b) Preventive detention in hospital

As argued in Chapter 6, preventive detention of personality disordered offenders in hospital also presents difficulties as this may be experienced as punishment by the individual even where this is not the intention. Ashworth and Zedner (2014) are critical of the lack of references in the MHA 1983 to the fact that detention in hospital constitutes a deprivation of liberty. Similarly to detention on the grounds of dangerousness, the authors are, however, willing to accept preventive detention in hospital on the grounds of "a significant risk of serious harm" to others as "a last resort", "for as short a time as possible, and in conditions as normal as feasible" (Ashworth and Zedner 2014, p.217). The use of compulsory powers in this context "should always be kept in proportion to the gravity of the prospective harm and the probability of it occurring" (Ashworth and Zedner 2014, p.219). In their view, detention in hospital after a criminal offence should only occur where the court finds treatment to

be necessary, that nothing less would be effective in protecting the public, and where the individual has been convicted of a serious offence carrying a sentence of at least seven years imprisonment. Furthermore, the individual should have a right to challenge decisions to detain him and to regular review of his detention, which should end as soon as it is no longer necessary to protect the public from "a significant risk of serious harm" (Ashworth and Zedner 2014, p.219). Whether detention takes place in hospital or prison, risk reductive treatments should also be available to enable the individual to work towards release.

These proposals are also similar to the "third service" idea. The requirement that treatment be "necessary" may not be adequate to avoid the misuse of hospital as a venue for the preventive detention of the dangerous given the broad interpretation given to "treatment" in the case law discussed in Chapter 6. The model proposed by the Richardson Committee, which would permit compulsion only in relation to those who lacked capacity and could be expected to benefit from treatment, was likely to leave out personality disordered offenders (Department of Health 1999a). This may, however, be a more honest way forward than the use of hospital as a venue for preventive detention where little treatment benefit could be expected. In the next section, it will be suggested that a form of non-punitive preventive detention similar to that permitted in Germany could go some way towards addressing the risks posed by the current system. These suggestions could form the basis for a future project on the normative limits to be placed on measures to address the dangers posed by particular personality disordered offenders.

(c) Non-punitive detention

In line with current judicial policy and the principles of desert, it is argued that life sentences should be reserved for murder, very serious offences and repeated serious offending. In order to comply better with the rules laid down in *M*, the punitive period of the sentence would be served in the prison and followed by indeterminate detention in a non-punitive environment. For those convicted of less serious offences who appear to present a risk of serious offending, a determinate prison sentence could be followed by an additional determinate period of preventive detention in a non-punitive environment. Provision could be made for the possibility of early release if reduced risk could be shown. Automatic release at the end of the determinate preventive period

would nevertheless follow. The indeterminate nature of the life sentence for the most serious offenders would also allow for eventual release, but this would not be automatic. This would help to counteract the disillusionment and hopelessness of whole life tariffs highlighted in *Vinter* while avoiding the additional punishment that comes with preventive detention served in a prison setting.

These forms of detention would have to be imposed after conviction to comply with Article 5 of the ECHR and retrospective preventive detention would not be permissible under Article 7. The result could be a system similar to that of Germany or the Netherlands, where an order of preventive detention can be imposed at conviction and served in a separate environment after the expiry of a period of punitive detention. In contrast to the "third service", such a system would not permit detention without a crime and would therefore avoid one of the fatal criticisms of Option B in the DSPD proposals. It would also avoid the use of hospitals as a venue for preventive detention in the absence of expected treatment benefit. Such a system would have the advantage of making the management of offenders deemed to be dangerous more visible and would permit the public to scrutinise the preventive measures taken in their name.

As discussed previously, the maturation process appears to be the most effective means of reducing re-offending in personality disordered and non-disordered offenders. There is an argument, therefore, for de-linking progress towards release from the provision of treatment, particularly in the case of personality disorder where evidence for the effectiveness of risk-reducing treatments continues to prove elusive. In order to reduce levels of coercion that may jeopardise treatment or lead to further punishment, one way forward could be to provide rehabilitation on a voluntary basis rather than as a means of demonstrating suitability for release. Egardo Rotman (1990) and Sam Lewis (2005) argue that rehabilitation can have a place within a system largely based on retributive punishment, as it can have a humanising influence and mitigate some of the damaging effects of incarceration on prisoners, and even improve their prospects of a crime-free and productive life post-release. These authors promote the idea of a right to rehabilitation and a reciprocal duty incumbent on the authorities to provide rehabilitative interventions to prisoners who wish to avail of them. On the other hand, they argue that the authorities should abstain from forcing unwilling prisoners to participate, including by making participation a condition of release.

In order to move towards a humanising model, interventions aimed at reducing risk to the public would be optional and deployed alongside interventions oriented towards enhancing wellbeing and countering the negative effects of detention. The German Constitutional Court has made recommendations along these lines for the German system of preventive detention (see Drenkhahn *et al.* 2012). It further stipulates that the regime of preventive detention should be oriented towards release and provide a means of re-socialising and re-integrating offenders through day release. Such an approach may better prepare detainees for life on the outside than risk reduction programmes conducted within the prison walls with few opportunities for testing out new skills.

Such a system would, however, demand greater tolerance of the risks posed by the release and re-integration of personality disordered offenders. It may also provide less symbolic reassurance than indeterminate periods of detention for those deemed to pose a risk. A rational expert-led system of preventive detention may risk backlash from the "redemptive" side of democracy described by Margaret Canovan (1999). She argues that populism should not be dismissed as "a symptom of backwardness that might be outgrown" but may be perceived as "a shadow cast by democracy itself" (Canovan 1999, p.3). In this view, populism is produced by a fundamental conflict between the two faces of democracy: the pragmatic and the redemptive. The pragmatic face conceives democracy as a system of governance capable of resolving conflicts and moderating passions, whereas the redemptive face promises "salvation" and "power to the people" (Canovan 1999, p.2; p.8). Instrumental or "rational" responses to objective levels of risk may therefore not be enough to provide symbolic reassurance that "something" is being "done" in response to public fears.

Proposals to open up criminal justice policymaking to "deliberative" (Green 2006) or "participatory" (Johnstone 2000) democracy may go some way to alleviate the struggles of government to appease the public desire for direct power and the expression of their will (Canovan 1999) and allow more rational decision-making. The issue of dangerous personality disordered offenders appears already to have lost some of its political "heat". Harry Annison notes that former Chancellor Ken Clarke was able to abolish the IPP sentence and replace it with the more limited LASPO 2012 regime due to his "characteristic resistance to media criticism" (Annison 2015, p.169). He may have been helped by the fact the steps were taken early on in the term of a Conservative-led

Coalition government wishing to distinguish itself from the previous Labour administration and not yet subject to the pressures of seeking re-election.

On the other hand, the increase in preventive measures against terrorists in the years after the attacks on 11th September 2001 indicate that public and governmental attention may have simply shifted to focus on a different type of dangerous offender, one who threatens the safety of the public and the security of the state more directly. Recent calls from Prime Minister David Cameron (2016) to introduce mandatory "de-radicalisation programmes" for those convicted of terrorist offences indicate that this group has also been selected for coercive rehabilitative interventions aimed at moulding those who pose a threat to society into responsible citizens. This implies that dangerous individuals and public fears they provoke will continue to present a challenge and indicates the enduring appeal of inclusive and exclusionary approaches to offenders judged to be dangerous but potentially redeemable.

8. Conclusion

In this chapter it has been argued that punishment, rehabilitation and incapacitation all form part of a response to the dangers posed to the public by dangerous personality disordered offenders. Law and policy in this area seeks to protect and reassure a vulnerable public while also attempting to separate out redeemable individuals and mould them into responsible citizens. Despite the more modern focus on risk factors, it is clear that a concern for enhancing individual welfare through rehabilitative efforts has survived the demise of the "penal welfare" era. As in those times, the rehabilitation of offenders continues to be influenced by notions of "reform" through punishment and justified on the grounds that it will reduce crime and promote wellbeing. In light of the particularities of the personality disordered offender, however, this may not be an adequate response as coercive interventions are less likely to succeed and may in fact subject the offender to further harsh treatment.

Given the clear priority accorded to security over individual liberty in the "balance" struck by the DSPD proposals it has also been argued that rehabilitation may merely be an effort to render coercive preventive measures taken in the pursuit of security more palatable for liberal governments. Furthermore, reliance on rehabilitative interventions

as a means of "balancing" competing rights in the jurisprudence of the ECtHR may not be an adequate safeguard against disproportionate punishment. A system of non-punitive preventive detention that de-links progress from participation in rehabilitative interventions could be one way forward. Any proposals to reform the system would, however, have to take into account the symbolic nature of efforts to reassure the public that they are protected against those who provoke fear.

Chapter 8: Conclusion

1. Proactive Policymaking

The aim of the first half of this thesis was to investigate where the DSPD initiative came from and why it came about when it did. It has been argued that, rather than a "populist law and order reaction" (Mullen 2007, s.3) to public fears provoked by a handful of high profile cases, the DSPD initiative was an attempt to respond to long-standing problems. The plans were, however, given greater impetus by public concerns surrounding high profile cases of crimes committed by mentally disordered individuals and the release of notorious offenders from prison. This led to a sense that the government had to be "seen to be doing something" about an issue of public concern.

As Rutherford suggests, the 1999 DSPD proposals "are more appropriately located within a proactive rather than a reactive scheme" (Rutherford 2006, p.79-80). A small group of civil servants drawn from the Home Office and Department of Health came together in 1997 to continue work on the issue of dangerous individuals being released from determinate prison sentences that had begun as far back as 1975 (Butler 1975). They also sought to strike a balance between the need to protect the public and the need to attend to the welfare of a damaged population. Inspired by systems in place in the Netherlands, Germany, Canada and the USA, they sought to create a British solution to respond to the range of problems the DSPD group posed for public protection, the reputation of the government, and the work of the prison and secure hospital systems.

While well-intentioned, their radical proposals for civil detention were met with staunch opposition from psychiatrists, patient groups and legal experts. The proposals were characterised as the creation of a dubious psychiatric diagnosis rather than as an attempt to define a group who posed longstanding problems. The eventual DSPD programme was later accused of pursuing the mere "warehousing" of individuals who provoke public fears (Tyrer *et al.* 2010, p.97). Contrary to this account, it has been argued here that therapy was an integral part of the programme stemming from the ambitions of the early policymakers. An impression of mere containment was, however, created by a combination of unrealistic expectations of what could be achieved in a short period of

time with a very difficult group of patients and evaluations that were commissioned too early.

A further aim of this thesis was to develop a critical account of the more inclusive or "progressive" elements of the DSPD initiative that have been neglected in previous criminological analyses. In particular, the research sought to explain the dual "tough" and "progressive" appearance of the DSPD programme identified by Toby Seddon (2008). The history of the proposals indicates that their "hybrid" nature may be attributable in part to the diverging interests of the Home Office and Department of Health. These were respectively characterised by interviewees as "public protection" and "wellbeing". The division was not as clear-cut as it may seem, however, as ministers and officials from both the Department of Health and Home Office voiced their support for both strands. Furthermore, concerns with public protection and the wellbeing of prisoners and patients crossed the divide between the mental health and criminal justice systems. The history of efforts to deal with the problems presented by personality disordered patients in the secure hospitals reflected a concern with protecting the public, or at least avoiding attracting blame for patients who reoffended (see; Butler 1975; Dell and Robertson 1988; Fallon 1999). The government was also concerned to address the poor quality of mental health care within prisons (Reed 1992; 1994) and to improve prison conditions following episodes of prisoner unrest and rioting in the 1980s (Walmsley 1991).

2. Learning Lessons?

Building on the analysis of the origins of the DSPD concept in Chapter 2, it has been argued that the DSPD initiative and the subsequent DSPD programme were based on a compromise that was heavily reliant on the discovery of new and effective treatments for personality disorder. These treatments were needed to strike a "balance" between the rights and interests of the public and those of dangerous individuals (Boateng and Sharland 1999). The DSPD programme continued in the spirit of the DSPD "evangelists" (Peay 2011a, p.238) and sought to marry together the interests of the Home Office and the Department of Health by improving treatment provision for a difficult and neglected group. In the rush to "be seen to be doing something" about a

high profile issue of public concern and to take a therapeutically optimistic stance, however, those behind the DSPD programme seemed to disregard some important lessons from past experience. Furthermore, by aligning itself with pre-existing legal and institutional structures, the DSPD programme in many ways perpetuated the difficulties experienced by the prison and secure hospital systems. This included a number of disgruntled patients and prisoners resisting treatment impeding the work of the unit, participants spending long periods of time "waiting" in "custodial" care, high rates of staff burn-out and turnover, and conflicts between the therapeutic ethos of the units and the entrenched cultures and concerns of the prisons and hospitals that housed them.

The story presented in the first two chapters of this thesis highlights the pitfalls of optimism coupled with short-termism and a failure to take full account of past experience. It also indicates the importance of continuity in the implementation of grand policies. The vision of the early DSPD "evangelists" (Peay 2011a, p.238) for an integrated "end-to-end" system for those with personality disorder was neglected as the pilots got underway and key actors moved on. The survival of the "myth" that Michael Stone was an "untreatable" psychopath in the minds of those involved with the latest attempt to deal with the DSPD group also indicates that the narrative of the original working group has been lost amidst media and political constructions of the problem of dangerous offenders and the measures taken to address it. Thus, the radical plans of the early policymakers eventually escaped their creators.

The developers of the OPDP have learned some lessons from the DSPD programme, however, and it in many ways represents a more concerted effort to follow through on the plans for the construction of an integrated system with adequate progression for prisoners. By deciding not to undertake a randomised controlled trial or to conduct a long term follow-up of the DSPD cohort, however, those responsible for the OPDP have missed another promising chance to improve the evidence base for the treatment of personality disorder. As the OPDP is still in its early stages and the study period for the recently commissioned evaluation is short, its potential to produce robust evidence of effectiveness is likely to be limited. The decision to expand the capacity of the treatment and progression units under the OPDP appears ill-advised given the continuing uncertainty surrounding the effectiveness of treatments with the DSPD group in reducing their risk of reoffending and allowing them to progress towards release.

Expansion may, however, reflect the importance of the DSPD programme as a cost effective means of managing difficult prisoners and continuously monitoring their risk levels. These aims may be just as important as the aim of effecting long-term reductions in their risk of recidivism and facilitating their social reintegration.

3. Risk Management and the Medicalisation of Offending

A further aim of the first part of this thesis was to examine whether the OPDP was a better response to the problems posed by the DSPD group than the original DSPD programme. It has been argued that a movement towards risk management and away from health outcomes is reflected in the less optimistic and perhaps more realistic stance of the OPDP towards treatment. The initiative is also to increasingly target high risk offenders and those who are less likely to be motivated to engage with treatment. This indicates that the programme is "focusing on narrower horizons" (Civil Servant) and that the programme has been co-opted into the pursuit of managing prisoners and reducing reoffending rates. In light of this, the extent to which the OPDP will be able to achieve the stated goal of "reducing health inequalities" (Bradley 2009) is in doubt. The focus on reducing reoffending and managing risk efficiently appears to leave less room for welfare-enhancing interventions. Nevertheless, the OPDP continues to incorporate more holistic treatment approaches, such as the trauma focused programme at HMP Whitemoor (Saradjian, Murphy and McVey 2010) and treatments such as DBT aimed at reducing self-harming behaviours and improving overall functioning (Linehan 1993). The OPDP may therefore be distinguished from the Canadian "risk/need" offending behaviour programmes described by Kelly Hannah-Moffat (2005) and indicates that the motivations of the early DSPD policymakers have not been completely forgotten. It also demonstrates the survival of health concerns, which may be linked to the background of forensic psychologists as mental health practitioners.

The inclusion of prisoners who have not been diagnosed with a personality disorder on a "personality disorder pathway" is surprising, however, and seems to suggest that the OPDP may come to encompass any prisoner judged to be at high risk of reoffending who poses management difficulties in prisons. The generality of the definition of "severe personality disorder" used by the OPDP indicates that any disruptive or

disturbing behaviour is now to be viewed through the lens of personality disorder. A movement towards the medicalization of offending may also be discerned in the use of psychological offending behaviour programmes with mainstream offenders.

Viewing prisoners' acts of resistance through the lens of personality disorder shifts attention away from the coercion that acts on prisoners and the struggles they experience in maintaining a sense of self and agency within the prison (Crewe 2011). This may increase the "pains of imprisonment" for prisoners with personality disorder and thus the hard treatment and punishment they receive for their offending. The use of psychological therapies within the prison setting also exposes the vulnerabilities of a group with a common history of trauma (Jones 2015) and generates risks for participants that must be carefully managed (Genders and Player 2014). The "punitive" nature of "post-modern" rehabilitation and offending behaviour programmes further indicates that individuals selected for the DSPD programme or OPDP may be punished disproportionately to their crimes.

4. Jeopardising Treatment and Progress

It has been argued here that placement on the OPDP may also slow prisoners' progress through the prison and secure hospital systems. Viewing the behaviour of prisoners and patients through the lens of personality disorder poses difficulties for assessing reductions in risk of reoffending, as acts of both compliance with and resistance to treatment may be interpreted as a product of personality disorder in a troubling Catch-22 (see Lacombe 2007). The coercive nature of the prison environment may also jeopardise the effectiveness of interventions that require motivation to change on behalf of the patient. On the other hand, individuals such as those in Leon McRae's (2013) study who sought entry onto treatment programmes in the hope of progressing towards release may be disappointed as the effectiveness of the interventions provided in reducing risk remains in doubt and rehabilitation is not a clear route towards release.

As reflected in the cases of *Guntrip* and *Falconer*, participation in the DSPD programme or OPDP has become an administrative requirement for prisoners assessed to be suitable. This is despite the misgivings expressed by Parole Board members in the MEMOS study regarding the effectiveness of personality disorder treatment, the ability

of the DSPD programme to adequately test out prisoners' risk of reoffending, and the "unknowns" introduced by a new treatment programme into a highly structured system (Trebilcock and Weaver 2010a; 2012a). Furthermore, the "culture of risk aversion" within the criminal justice and mental health systems (Jacobson and Hough 2010, p.5) reflected in Parole Board and Mental Health Review Tribunal decision-making in relation to the DSPD group (Trebilcock and Weaver 2010a; 2012a; 2012b) is likely to continue to pose further barriers to release.

Viewed together, the developments in law, policy and practice that have taken place since 1999 indicate that a significant extension of preventive detention and control over personality disordered offenders has been achieved through administrative means without the need to create a "radical" third service. Rather than taking place in a separate service, however, preventive detention on the grounds of risk is secured through a combination of indeterminate sentences and transfer to hospital for detention at the end of sentence. By staying within existing legal frameworks, and in particular using discretionary life sentences and IPP sentences to facilitate preventive detention, the DSPD programme and the OPDP present a risk of excessive punishment for prisoners who are selected for participation. Supervision in the community has also been significantly increased, and breaches of licence conditions or civil orders such as VOOs and SOPOs have the effect of triggering detention. This can come into play even where the offender has been found not guilty by reason of insanity or unfit to plead.

5. Prioritising Punishment and Public Protection

The legal and policy framework also reflects a clear preference for managing personality disordered offenders in the prison system and for punishing them rather than attending to their welfare. A choice was made under the OPDP to focus on building a criminal justice pathway and treatment is predominantly to be delivered in prison. This trend may also be discerned in *Vowles* as the CA prioritises punishing mentally disordered offenders for "any element or particle of responsibility" they bear for their offences (Ashworth and Mackay 2015). The prioritisation of punitive outcomes for personality disordered offenders has the potential to be anti-therapeutic and ignores the risks imprisonment poses for vulnerable individuals with a history of trauma and social

deprivation. The case law also prioritises punishment and public protection even where this is likely to result in increased risks to staff and inmates in the institutions that house personality disordered offenders (*Cooper*). This indicates that the safety of prison staff and other inmates may also be sacrificed in the name of public protection.

The current pragmatic and precautionary approach of the law obscures the deeper question of whether personality disordered offenders can rightly be held criminally responsible given the volitional and emotional deficits associated with their disorders. It also overlooks the difficulties such offenders may have in responding to the experience of punishment and efforts at their rehabilitation in the expected ways. While regarding personality disordered offenders as culpable for offending resulting from their own defective personality traits and failures in self-government, the system also treats them as responsible for working on their characters by engaging in rehabilitation. Their failure to meet their moral duty to participate in rehabilitative interventions and reassure others that they do not pose a threat results in continued detention and punishment through deprivation of liberty.

Where an individual can no longer be detained in prison, secure hospitals continue to be used as a venue for preventive detention in order to protect the public. This approach may perpetuate the long term "custodial" approach of the hospital system towards "undischargeable" patients outlined by Dell and Robertson (1988) in the mid-1980s. The practice of "ghosting" (Taylor 2011, p.294) or late transfers to hospital remains a legal possibility and may be expected to increase following the abolition of the IPP sentence. The hospitals are to cater for this disgruntled group without the benefit of the extra resources and higher staffing levels of the DSPD programme. This casts further doubt on the extent to which the OPDP can be viewed as an improvement on the DSPD programme that went before it. It also indicates that the OPDP is unlikely to be an adequate response to the myriad of difficulties posed by the DSPD group for the prison and hospital systems.

6. Balancing Rights?

In its early days, the DSPD initiative aimed to strike an appropriate "balance" between the competing "rights" of the public and those of personality disordered offenders

(Boateng and Sharland 1999). However, it was clear that, in the case of conflict, the need to protect the public would prevail (Tyrer *et al.* 2009). Here it has been argued that the current legal framework also prioritises the rights of a nebulous "public" to protection from uncertain harms over the right of concrete offenders not to be subjected to disproportionate punishment and to have the chance to re-integrate into society. At first glance, the ECtHR's position in cases such as *James* and *Vinter* appears to recognise a "right to rehabilitation" for prisoners and a duty on behalf of the state to provide such interventions (Van Zyl Smit *et al.* 2014). However, the ECtHR's enforcement of a broad duty on behalf of governments "to afford general protection to society against the potential acts" of prisoners serving sentences for violent crimes (*Mastromatteo* para. 69) has clear potential to conflict with its commitment to offender re-integration. The *Maiorano* case demonstrates the weakness of the ECtHR's attachment to the rights of offenders in cases of serious reoffending. The risk aversion demonstrated by the ECtHR also casts doubt on the potential for rehabilitation to act as a means of rendering the preventive detention of dangerous offenders proportionate to the risks they pose to the public. The implication in *Vinter* that rehabilitation can act as a brake on the inhuman and degrading treatment imposed by a whole life sentence appears to be misguided. Current technical capabilities do not allow us to accurately assess the need to protect the public from individual offenders and rehabilitative interventions may be experienced as punitive in themselves.

It is argued, therefore, that the combination of the OPDP and the legal framework cannot be said to strike a fair "balance" between the rights of the public and those of the offender. More than this, it is argued that it cannot be expected to. The priority placed on the protection of the public over the rehabilitation of the offender in both law and policy indicates that rather than striking a balance between competing individual rights, the bargain in fact trades individual liberty for collective security. As Mark Neocleous argues, the idea of a "balance" between security and liberty "is essentially a liberal myth […] that in turn masks the fact that liberalism's key category is not liberty, but security" (Neocleous 2007, p.131).

Building on Peter Ramsay's (2012a) analysis of "the ideology of vulnerable autonomy", it has been argued that, by detaining dangerous personality disordered offenders, the state seeks to reassure its vulnerable citizens that they will be protected from dangerous

individuals who are not deterred from violent or sexual offending by the force of the criminal law. As in the time of the "platonic guardians" described by Ian Loader (2006), the appeal to rehabilitation may be considered a means of rendering the "troubling and distasteful practice" (Loader 2006, p.565) of preventive detention and punishment easier for liberal governments to swallow. In this way, it also serves to obscure the "profound questions of morality" surrounding the use of imprisonment that Mary Bosworth argues "should detain us all" (Bosworth 2007, p.69).

7. Contribution

The research and critical analysis presented in this thesis contribute significantly to the existing state of knowledge on the interactions between law and policy governing personality disordered offenders in two large and complex systems. The thesis also draws on original insights from policymakers, practitioners and academics with first-hand knowledge of the inner workings of policy and practice in this area, bringing to light aspects of the policy development and implementation processes not previously available. Furthermore, the research has examined in detail the claims made by the criminological literature in relation to the DSPD initiative and broader trends in criminal justice policy and has developed a more nuanced account of the assumptions underlying recent attempts to govern personality disordered offenders. In particular, the thesis has drawn attention to the punitive potential of rehabilitative interventions with personality disordered offenders and has called into question the reliance on rehabilitation as a legal limit on preventive detention and punishment.

The thesis contributes to current debates on the relationship between rehabilitation and punishment and trends in penal policymaking and practice by highlighting the continuing relevance of the modernist project of rehabilitation and its relationship with Victorian approaches to the "reform" of defective criminal characters. It has also shown that the concept of criminal character is a more useful lens than positivism or classicism for interpreting the seemingly conflicting conceptions of the personality disordered offender deployed in law, policy and practice. Rather than conceiving of the personality disordered offender as an entirely free actor or as the victim of his own biology, it has been argued, following Rose, that the DSPD offender is "the responsible subject of moral community guided – or misguided – by ethical self-steering mechanisms" (Rose

2000, p.321). In this light, the offender can be held responsible not only for his offending but also for redeeming himself through engagement with rehabilitative interventions.

The concept of character also helps to highlight the role of coercion and the reform of the offender, which is more compatible with the enterprise of punishment than a medical model that removes responsibility from the patient. Ironically, enforcing a duty for offenders to engage in treatment as an administrative requirement to show their suitability for release may be expected to undermine the effectiveness of treatments that require willing participation and lead to ever longer periods of incarceration.

The discussion in this thesis has also countered accounts that see DSPD merely as a continuation of exclusionary practices towards dangerous "monsters" (Seddon 2008). Rather, rehabilitation and eventual release may be characterised as a response to the redeemable offender whilst preventive detention is a response to the irredeemable "monster". As scientific expertise has not yet been able to offer a means of distinguishing between these two groups, preventive detention is deployed for all while the prospect of reform is left open. It has further highlighted that scientific expertise continues to be relevant for penal policy but is drawn upon selectively. Thus, rather than stemming from a "loss of faith in the capacity of psychiatric experts to reform offenders" (McRae 2013, p.53), the DSPD initiative was a means of engaging with those professionals who share the government's optimistic stance on treatment.

The thesis has also brought insights from criminological literature to bear on the legal literature, going beyond the question of whether detention in hospital is intended to be punitive (Stanton-Ife 2012) to uncover its punitive effects. Furthermore, the research has highlighted the possibility that punishment may be experienced more harshly by those marked out for therapeutic interventions in coercive environments that may be re-traumatising for vulnerable individuals (Jones 2015; Moore and Hannah-Moffat 2005; Genders and Player 2014).

The research presented in this thesis is timely given that the resurgence of forms of character liability including increased powers of supervision and forms of risk-based detention (Lacey 2011; 2016) has been accompanied by a revival of rehabilitation as an aim of the criminal justice system (Robinson 2008). While acknowledging that

rehabilitative interventions increasingly focus on reducing reoffending, the research presented in this thesis highlights that welfarist considerations have not been forgotten. Thus, the rehabilitation of dangerous offenders in the English context differs from the Canadian system studied by Kelly Hannah-Moffat (2005) and incorporates a concern for meeting the non-criminogenic treatment needs of a troubled and troubling group of patients and prisoners.

8. Limitations and Future Research

It has been argued in this thesis that the combination of preventive detention achieved through the use of indeterminate sentencing and detention under the MHA 1983 leads to disproportionate punishment and that the use of rehabilitative interventions in prisons can increase the experience of punishment. The analysis draws on empirical research conducted with prisoners, such as Ben Crewe's (2011) work on the modern pains of imprisonment, and also on the accounts of patients and prisoners on the DSPD programme (Tyrer *et al.* 2007; Burns *et al.* 2011). A fuller empirical study would explore in further detail whether placement on the OPDP and transfer to hospital is subjectively experienced as additional punishment. Another relevant area for future research is the conflict between therapeutic aims and prison culture and whether healthcare ethics, including the aims of beneficence and non-malfeasance, can be reconciled with an institution that is primarily intended to deprive individuals of their liberty as a punishment.

It seems from the analysis of the structure of the Parole Board system and the research conducted by Julie Trebilcock and Tim Weaver (2010a; 2012a) with Parole Board members that placement on the DSPD programme or the OPDP has the potential to slow progress through prison. It has also been argued that participation on the DSPD programme and the OPDP has become an administrative requirement and that this can be expected to result in longer periods of incarceration. A fuller study of the trajectories of personality disordered offenders through the prison and health systems could provide empirical evidence of this process. The post-conviction stage in the criminal justice process, and in particular categorisation decisions and Parole Board decision-making, is a neglected area of research that warrants greater attention. In particular, administrative

decision-making within the prison system in relation to the security categorisation of prisoners requires greater scrutiny in light of the importance of these decisions for prisoner progress through the system.

The empirical element of the current study is limited to 17 interviews conducted with practitioners, academics and policymakers and drew on a small sample of key informants. It was not possible to interview all those involved but attempts were made to achieve a balanced sample of views by interviewing both critics and proponents of the DSPD programme and the OPDP. The present research cannot pretend, however, to replicate the scale of previous studies of penal policy making in which much larger numbers of actors were interviewed (e.g. Annison 2015). On the other hand, the normative analysis and discussion of case law and human rights law undertaken in the second half of the thesis goes beyond accounts that focus on the political context of policymaking. In this sense, the thesis takes a more critical look at aspects of the system that have been neglected by other accounts, such as the potential for excessive punishment arising from the use of indeterminate sentences as a preventive measure and the reliance on rehabilitative intervention as a limit on excessive periods of detention.

The sentencing guidance issued by the Court of Appeal in *Vowles* suggests a continuing role for the notion of "treatability" and a trend towards courts taking a more sceptical view of psychiatric evidence and focusing more closely on reassuring and protecting the public. These trends deserve further exploration, particularly in light of the role of "treatability" as a double-edged sword for personality disordered offenders highlighted in this thesis. It suggests that the judiciary has become increasingly risk-averse, perhaps due to the focus of successive governments on protecting the public from dangerous offenders. As indicated in this thesis, the sentencing of mentally disordered offenders and the role of expert evidence in judicial decision-making is an under-researched area and one that warrants further exploration in light of broader trends in criminal justice policy.

The research in this thesis has focused on the legal regime governing the detention and treatment of personality disordered offenders considered dangerous in England and Wales and on a treatment programme located in English prisons and secure hospitals. The choice was made to focus on this jurisdiction due to the availability of literature on the controversial DSPD proposals and the recent changes to mental health law under the

MHA 2007 and the law of sentencing under the CJA 2003 and LASPO 2012. A comparative dimension to the research was not feasible given the timeframe of the study and the scale of the mental health and criminal justice systems studied. Future research in this area could draw a comparison with the Scottish approach to dangerous offenders and the different direction taken in the reform of mental health law in this jurisdiction. The Mental Health (Care and Treatment) (Scotland) Act 2003 took a more liberal direction than the MHA 2007 and is structured by a number of principles, including that treatment should be of maximum benefit to the patient and that powers of detention and compulsory treatment should be exercised in a manner least restrictive of the patient's freedom.

The experiences of other jurisdictions could also be drawn upon in devising suggestions to improve the English and Welsh system and open up new avenues of inquiry. It has been suggested that a new form of non-punitive preventive detention drawing on the "third service" idea could present one way forward. The Dutch and German systems touched on in this thesis warrant further study given the influence of these systems on the ECtHR jurisprudence. Comparisons can also be drawn with the Canadian and American systems, which appear to focus more narrowly on managing and reducing risk rather than on addressing mental health needs. A comparison between the cultures of different jurisdictions and their relative tolerance and intolerance of the risk of reoffending by convicted offenders would also prove illuminating. It may also present further insights into the need for symbolic efforts to reassure the public.

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